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EPIDEMIC DYSENTERY, AS IT OCCURRED IN NEW GARDEN, ETC., IN 1824.

BY E. MICHENER, M. D.,
Of Toughkenamon, Chester County, Pa.

The summer of 1824 was rendered memorable, in this portion of Chester county, by the sudden irruption of a violent epidemic dysentery, the history of which does not appear to have been written. After the lapse of sixty years, I find myself the only surviving medical witness of its fearful ravages. With the aid of a few brief notes, and a memory retentive of the more impressive events of long ago, I will endeavor to preserve a short history of the disease, as I witnessed it. My report must necessarily appear in the tawdry dress of an egotist.

I can not now recall the meteorological features of the season. But it may not be irrelevant to record the fact that there was a destructive tornado in the near vicinity, July 6, just about the time of its commencement. (See History of Chester County, p. 458.)

The epidemic of 1824 originally occupied a belt little over two miles wide, and ten to twelve miles in length, including the south-western part of Kennett, the southern parts of New Garden, Londongrove, and New London (now Franklin) townships. Indeed, traces of it were reported almost from the Delaware to the Susquehanna. As the season advanced, there were a few extra limital cases. But so well were its limits defined, that while numerous cases, and several deaths, occurred in the Toughkenamon Valley, there was

only one solitary and very slight case of it north of the hill.

It is humiliating to acknowledge that the recent removal of the late Doctors John Ross, father and son, had brought forward several rival claimants for a pittance of their extensive practice, and whose jealousies had closed the way for friendly and professional intercourse among them.

Dr. Palmer Chamberlain was located at New Garden; Dr. B. I. Pennock at Londongrove; Dr. Robert Allison near Chatham; Dr. Josiah Ankrim at Jennerville, and the writer at Prestonville. Drs. Allison and Peinock were out of the district and saw only a few cases. Dr. Ankrim was the only one I met in consultation. We often visited each other's patients. More than this, little was known of each other's opinions and practice. The highest rate of mortality was certainly in New Garden; more especially in adults. It is due to Dr. Chamberlain to say that the disease began in his district, and, as I believe, was most general and most malignant there. In evidence of this, the records show that during the three months of its prevalence there were more than sixty of its victims buried in the New Garden grounds, three of whom were my patients.

I confess to the charge of being *radical* in the treatment of acute inflammatory diseases. It has been my life motto, "It is easier to crush the egg, than to kill the envenomed monster it would produce."

During a space of nearly three months, I visited about thirty patients daily, often several in the same family, and can conscientiously—not boastingly—declare that during this period I lost only two patients over *nine years old*, both of

whom were in bed when attacked with dysentery. The sequel will show a much higher mortality in children.

These notes will, I think, show the propriety of considering the disease as it appeared in *adults* and in *children* separately.

AS IT APPEARED IN ADULTS.

It is probable that sporadic cases of dysentery, which may occur at any season, generally in autumn, may often be a primary *colitis*, from incidental causes. But when it assumes an *epidemic* character, as in this instance, I apprehend that it has a broader and deeper origin.

The prominent symptoms of this epidemic, as I interpreted them, indicated a *primary congestion*, beginning, perhaps, in the liver, and speedily extending to the entire portal system, and if left to its course, rapidly ending in *acute inflammation* of the viscera involved. The truth of these general pathological views is best determined by the success of treatment based upon them.*

I will illustrate this by cases.

CASE 1. 1824-8-28.—Was called at an early hour this morning to see M. S—, a young woman aged 18, of healthy parents, and possessing a vigorous constitution.

She had a heavy chill last evening, with its accompaniments of pain in the head and back, followed by fever, sense of fullness, weight, and a burning sensation rather than pain, especially in the hepatic and gastric regions. Later she had sick stomach and diarrhoea.

Twelve hours after the chill, I found her with the symptoms aggravated. High fever, skin hot, pulse full and frequent, throbbing pain in the head, distressing sickness of stomach without vomiting. The abdomen was generally tense and quite tender on pressure, especially in the right hypochondrium, with pain in the latter locality. She was now having frequent mucous stools, with tenesmus and streaks of blood—the work of twelve hours.

Was this an *ordinary form of dysentery*? Was it a *primary colitis*? I could not diagnose it so.

* Hunger is seldom counted a *morbid symptom*. Here it was, in some cases, the first sign noticed.

A. B.—, a very delicate woman, felt unwell and yet inclined to take an ordinary breakfast. Two hours later I found her taking a lunch. She said that she felt so hungry she could not refrain. She was a sick woman long before night.

I met M. T— one morning at a neighbor's and inquired for her three-year-old boy. She replied, "Right well. He ate a very hearty breakfast, and in an hour after, came in calling for something to eat." It was not a new story. I told her to go home and she would find him sick. She did so. In four days he was dead.

True to my convictions, I immediately bled her to $\frac{3}{4}$ xvij., in a sitting position, with great relief to her sufferings, even while the blood was flowing. This was immediately followed by hyd. submur., grs. xx., and sulph. magnes., a tablespoonful in an hour after, and repeated every hour until *copious stools have been obtained without tenesmus*. This was a *sine qua non*.

This practice was based upon many previous observations, as well as on theory. I had found that in well-developed cases relief was preceded and could only be obtained by a copious discharge of a dark pulaceous mass without tenesmus or gripping pain. In a few instances, this occurred almost spontaneously. The first case I saw, an eight-year-old boy, I found on the porch, sitting over a pile of more than half a pint of such stool. He required very little medicine. Nature had nearly done the work.

29th. As I had anticipated, the medicine of yesterday had procured several copious and free evacuations, with almost entire relief of suffering through the day. After an hour's sleep, she awoke with some return of former symptoms, though in a much mitigated form. The blood drawn yesterday had formed a thick buff, which is contracted to the size of a half dollar; but this is now all figee.

The cause appearing not fully removed, I repeated the course. Took $\frac{3}{4}$ xij. of blood, with marked relief to the remaining suffering, with the calomel and salts, as directed yesterday.

30th. The medicine procured free evacuations, though less abundant, and afforded entire relief. She had slept well during the night, and now expresses herself quite comfortable. A Dover's powder at night, with rest and a careful diet, was all the attention she required. Convalescence was rapid and uninterrupted.

I give this as a typical case; others of similar character might be added. Owing to obvious causes, this heroic treatment could not be employed in all cases, mostly resulting in prolonged treatment and increased exhaustion.

Strange as it may seem, my patient lived to marry and raise a family of children, who could rise up and call her blessed.

CASE 2. While the preceding case was still under notice, I was called to attend another, under somewhat less favorable conditions. Catharine, the wife of D. S—, and the mother of nine children, naturally of a good constitution, but much broken by early and rapid child-bearing, and the burdens incident to a large family, was attacked with the prevailing disease early in the

evening of the 1st of 9th month. I was sent for early in the morning, but being absent from home all day, did not see her until after nightfall—some twenty-eight hours after the attack. The symptoms were so similar to those already given that I need not repeat them. They were, however, more violent, and progressed more rapidly.

I found the entire abdomen tense, painful and intolerant of pressure. The tortina and tenesmus almost constant. The pulse was frequent, irregular, and feeble, with short and sighing respiration. She had severe pain in the head, with a hesitancy in answering questions, and sometimes incoherence. She had become despondent, and objected to anything but to die. Such a case I had not seen.

I gave my opinion frankly to the anxious husband that it was not probable that any means could save her. If anything was done, it must be *prompt and severe*; and if it failed, might even *hasten her death*. The immediate reply was, "Doctor, you know that I have entire confidence in you; do just what you think best." Who would betray such confidence? My mind was made up.

I ordered a hasty warm bath prepared, and in the interim, bled her to $\frac{3}{4}$ xviii, and immediately gave her hyd. subinur. $\frac{3}{4}$ ss., ipecac $\frac{3}{4}$ j. M. ft. pulv.; then placed her in the bath. The bleeding had a very soothing effect, and when she got into the water, was comparatively easy. While still in the bath, the emetic produced two or three free operations. She was then placed between blankets, with warm covering and a hot brick wrapped in a wet cloth to her feet. I then left for the night, with directions to give her a mild anodyne and stimulant mixture after each operation of the calomel.

The morning found my patient weak and exhausted, but indeed less so than when I first saw her. After an hour or two of rest, the medicine had produced several very copious stools in quick succession, after which she remained free of pain and inclined to sleep. From this time forward mild opiates and tonics, with good nursing, soon restored her to health.

This bold and decisive practice, as in the former case, was directed to the alone object—to *unload* the congested viscera before active inflammation and disorganization should take place. As the fulfillment of a prophecy is evidence of its truthfulness, so the result in this case is proof of a correct diagnosis. The sequents of the congestion vanished, even in less time than was required to produce them.

When will our physicians learn the practical

lesson, that a patient will recuperate from loss of blood before the assimilative functions have been seriously injured, much more readily and speedily than from anæmia where the whole organism has been exhausted by prolonged disease?

My patient recovered!! She did more!!! In due season she added four more sucklings to the flock, and completed the good old Irish dozen, and lived to a good old age.

In this disease, dysentery was *secondary*—the *sequence of congestion* in the superior viscera of the abdomen—and congestion only means an obstruction of the flow of blood and an accumulation in the obstructed vessels. The indications were plain. The demand for prompt relief was imperative before greater mischiefs should occur. Herein lies the secret of my success. How far other epidemics, or even sporadic cases of colitis, would be amenable to such treatment, I may not decide; but I have used it in the latter form of the disease with satisfaction.

In relation to large doses of calomel as a purgative, I wish to say that I have very frequently administered it in this epidemic, and in other acute diseases, in doses of xx to xxx grains, with most satisfactory results, and have not cause to regret it. It is scarce more annoying than a smaller quantity, while its power to calm morbid excitement and equalize the disturbed circulation is only second to that of the lancet.

NOTE.—Since this paper was written, Dr. T. has informed me that in conversation with Dr. Chamberlain some years ago about this dysentery, the doctor mentioned that I. M.—had been very bad, and despairing of the case, he gave him an unlimited dose of calomel ($\frac{3}{4}$ j., or more), and next day found that it had produced the happiest effects. His patient recovered.

THE INFANTILE FORM.

While no age or condition was exempt from the malady, its ratio of mortality was greatly increased by what I have termed the "Infantile Form,"—peradventure it was not a *superadded epidemic*. It usually occurred in children from three to four months to as many years—seldom later.

With the few and imperfect notes which I possess, I shall not attempt, at this late day, to give minute details. Usually from two or three to forty-eight hours from the first disturbance of the bowels symptoms simulating *cerebral inflammation* would suddenly appear. Sometimes at the first visit—skin hot, especially of the head; face flushed, eyes red and watery; child very fretful, sometimes with sudden starts and screams. Sooner or later, from two hours to as many days,

the excitement would abate, the skin become cool, the child would become listless and sink into stupor, coma, and death. So rapid were these changes in some cases that several children died on the second day, and without medical treatment. I believe it was always preceded by the bowel disturbance, yet they were often almost simultaneous.

It was under these appalling circumstances that I was called to treat this fatal *nondescript*, under a false garb; and I frankly acknowledge to having lost *fourteen out of the first seventeen* cases in quick succession. I could not learn that others were more successful.

Dr. Ankrim and I had frequently consulted, and often visited patients in company, and it was not without much serious thought and anxious inquiry; but it was one thing to feel that we were wrong, quite another to know and to do the right.

Like the dawn of morning, light comes slowly. Fortunately, an older boy (six or seven years) was passing nicely through a mild attack of dysentery, when he suddenly began to manifest the usual coolness and languor, without having shown the cerebral excitement. I invited Dr. Ankrim to see him with me the same evening. In answer to my inquiry, he replied, "He will die before to-morrow night, just as others have done." I then showed him a prescription which I had just prepared for the boy. His answer was, "If you give that, I will have to see your patient in the morning." It read—

R. Huxham's tincture,	2 ss.
Elixir paregoric,	3 ss.
Spirit. nit. dulcis,	3 ij.

M.—Give a teaspoonful in sugar-water every hour, if awake.

On our morning visit, we rejoiced to learn that soon after the second dose he slept quietly for two hours, and woke up quite refreshed. The stupor had passed off, the skin had become more natural. He was, in fact, quite comfortable, and made a speedy recovery.

I had now crossed the *Rubicon*. I had done more: I had anticipated, by a dozen years, the thrice-repeated discovery of Drs. Abercrombie, Hall, and Gooch, of *spurious hydrocephalus*. Of the value of my discovery I could not yet venture to judge. But I awaited, with much anxiety, the occurrence of another as a *test case*. It soon came. By the careful use of stimulants and tonics in conjunction with evacuants, my patient did well.

After the sad failures which I had experienced, it is with no little pleasure that I can state that

I was now able to reverse the bill of mortality to *three deaths out of seventeen cases*.

In observing these cases, I had constantly noticed the *sunken condition* of the fontanelle. It now became significant to distinguish between the true and spurious cephalic affection. I had often referred Dr. B. I. Pennock and others to this distinctive sign many years previous to the announcement of Dr. Watson in 1843, eighteen years after I had noticed it. Dr. Pennock used to often pass his jokes on me for allowing others to reap the reward of my discoveries, by neglecting to publish them.

An incident of the season: Dr. Pennock, then a young practitioner living at Londongrove, only three miles north of the infected Toughkenamon Valley, had been wondering what was the matter down there. A little babe of C. S.—'s was taken sick in the night, and Dr. Chamberlain sent for in the morning, but he, too, was sick, and Dr. Pennock saw it in the afternoon. Next morning I met the doctor on his way to see the child. I earnestly inquired his views in relation to the disease. He had none to give—he had only seen this child once, and had called on two of Chamberlain's sick in the evening. He had not noticed anything unusual. He did not think the child very ill. It is enough to say that he arrived at ten o'clock to learn that the child had been dead about an hour. This was too much for his sensitive nature. He did not want to see any more New Garden dysentery.

Now, kind readers, you have had the opportunity of knowing the extraordinary advance in the knowledge of pathology, diagnosis, and therapeutics within the past sixty years, may I claim your indulgence? May I remind you that where much is given, much will be required? And let me ask, can you show a better record than I have done, co-ordinate with the improved advantages which you enjoy?

The number of deaths cannot be ascertained. The interments at New Garden, West Grove, New London, and some scattering ones in other grounds, probably reached about one hundred and twenty.

SCIRRUS CARCINOMA OF THE STOMACH.

BY DANIEL LONGAKER, M. D.,

Of Philadelphia.

[Presented before the Northern Medical Association, February 23, 1883.]

Mr. H., German, married, at 48, without hereditary tendencies, was a moderate drinker, never to excess, of such liquors as wines and beer; no venereal history. Was of stout build, weighing

two hundred and forty pounds. Until three and a half years ago, he was in the enjoyment of excellent health. At that time he began to suffer from dyspepsia, manifested by such symptoms as a variable appetite, ravenous at one time, then bad; eructations; flatulency; discomfort, but no pain after eating, or at any time. From this time on, during the following three years, he tried various physicians without relief.

Six months ago he came under the observation and care of Dr. Trautmann, by whose courtesy I am enabled to report the case. At that time there was no decided loss of flesh, or great failure of strength. His countenance was of a pale, yellowish, rather icteric hue. He suffered from nausea after eating, flatulency, and there was slight soreness in the epigastric region. Bowels were costive at times only. Under the use of subnit. bismuth, with aloes and alkaline carbonates, his condition soon became decidedly improved, so much so that he only remained under observation as an office patient for about a month, when, considering himself much better, he did not deem it necessary to seek farther advice. From the peculiar hue of the skin, resembling somewhat that of jaundice, with the presence of a hard, indistinct mass in the neighborhood of the gall-bladder, and the absence of such marked gastric symptoms as would be expected from serious organic disease, cholelithiasis was supposed to be present as a concomitant condition.

His condition of apparent improvement continued only for a few weeks, when, beginning to lose flesh and strength rapidly, he became unable to leave his house. Under the impression that he now had consumption, upon the advice of his friends, he persisted for a short time in the use of an animal oil (dog fat). His gastric symptoms were now aggravated to a marked degree, but with appropriate treatment were soon again controlled. Constipation, with slight diarrhoea, a little vomiting and flatulency were noticed, and now for the first time, about three months ago, he began to have distinct pain referred to the epigastrium. It was never severe or lancinating, and most of the time he was entirely free from suffering. The flatulent distention of the abdomen was more cause of annoyance than the pain. From the presence of a tumor in the region of the pylorus, with symptoms referable to interference with the digestive function and the cachexia, marked carcinoma of the stomach was diagnosed. This opinion was negatived by one of our eminent diagnosticians, who unhesitatingly referred the malignant growth to head of the pancreas.

A short time after this, I observed the following

condition: A tumor, not as large as the hand, having a boggy feel, not tender to pressure, and occupying a position a little to the right of the median line. The ensiform cartilage was prominent, and displaced forwards. The tumor was not movable. There was slight tympanitic distension of the abdomen. He was emaciated and weak. His color presented that clayey appearance, characteristic of cancerous disease. He continued to take food in limited quantities, with no more suffering than has already been stated, until the termination of his life, three days ago. At no time was there vomiting of blood, or evacuation of melænae. Edema of the feet and legs appeared about three weeks before death.

Autopsy, thirty-six hours after death: Rigor mortis distinct. The body is greatly emaciated, and almost entirely destitute of subcutaneous fat. The peritoneal cavity contains a small quantity of fluid. The small intestines are normal. The transverse colon is extensively adherent in its middle portion, nothing abnormal in the ascending and descending part of it. The liver is anemic, pale and slightly diminished in size. Glissén's capsule is thickened and opaque. To the under surface of the liver is found adherent the transverse colon and the pyloric end of the stomach. The gall bladder contains the usual amount of bile. The stomach is not dilated; on the other hand, there is a distinct thickening of its coats. It contains a half pint of semi-fluid ingesta. At the greater curvature, and encroaching closely upon the pyloric orifice, is found a nodular mass, of a hard, tough consistence, larger than a hen's egg in size, but flattened, and showing a tendency to pass circularly around this portion; there is about one-fourth of the circumference which apparently is not yet invaded by the growth, being normal to the naked eye. In a few places, the mass shows signs of commencing ulceration. In limited portions of the mucous membrane the vessels are dilated, a few infarcts are noticed. The duodenum is stained with bile. The pancreas is normal. It is adherent to the pyloric end of the stomach. There is no obstruction of its duct. The kidneys and spleen are normal in size, and of macroscopic appearance. The capsules of the former are easily separated.

In the thoracic cavity a slight adhesion is found to exist between the pleura of the apex of the right lung and the costal investment of that membrane. There is here also a limited catarrhal pneumonia. With this exception, the lungs are normal. The heart is small, the valves are intact, it is filled with soft coagula.

The existence of the tumor in this case, with the marked cachexia, left no room for doubt as to its malignancy, but with the absence of the usual severe and decided gastric disturbance, the question of diagnosis with regard to its location was one of interest.

Flint, in his clinical medicine, referring to the recognition of diseases of the pancreas, carcinoma, among others, frankly states. "As a general statement, they defy diagnosis." "Happily for the diagnostician as well as patients, they are extremely rare in this situation." Even the absence of fatty diarrhea does not exclude pancreatic disease, though its presence renders it probable.

How the fact of a disease being extremely rare can be a consolation to the diagnostician, I cannot appreciate, unless we practically ignore their existence. But the case under observation may be the rare example, and then, at least, it must be admitted, it is not a consolation when the scalpel reveals a different condition from that which was suspected. Because certain diseases are rare, we are necessarily not familiar with their clinical phenomena, and hence their difficulty of recognition; but the effort to do so is certainly a laudable one, and should even a mistaken opinion be advanced, no disgrace to one's reputation can attach to it. But in case of uncertainty, he who ignores the rare and assumes the existence of the common, will be at least likely to be foiled.

**CASE OF OXALURIA.—TREATMENT.—
RECOVERY.**

BY JOSEPH L. BAUER, M. D.,
Of Saint Louis,
Surgeon to St. Mary's Hospital.

W. W., at 34, presented himself to me with the following history: Masturbation had been practiced in youth; had suffered from one attack of gonorrhœa; had always been fond of the opposite sex, and had freely indulged his sexual appetite. For the last two years, had suffered from irritability of the bladder, and frequent micturition; the latter disturbing him both day and night. At certain micturitions he suffered with pain along urethra, and at neck of bladder after urination. Occasionally, a muco-gelatinous discharge exuded from urethra; the urine presented flakes of mucus also. He suffered from hypochondria, indigestion, general pains, constipation, and partial impotency; of late, these symptoms have increased, and the patient, who has read a surfeit of marriage guides, believes he is losing his virility.

A personal examination elicited the following:

Pouting and inflamed meatus urethra; all efforts to pass instruments were resisted by the intense urethral hyperesthesia; examination per rectum disclosed sensitiveness about neck of bladder and membranous urethra. The prostate gland was tender and slightly enlarged. Urine acid, but presented no pathological conditions. In order to place the urethra and bladder in a condition for examination, the following treatment was pursued:

R. Potass. acetatis,	5 liiss.
Ext. buchu fluidi,	5 ss.
Ext. hyoscyami,	gr. xij.
Syr. gentianæ,	5 j.
Aqua distil.	q. s. ad. 5 vj.

M. D. S.—A tablespoonful every 3 hours.

Besides this a suppository of (10) ten grains of iodoform and five (5) drops of el. eucalyptol (Lauder), was placed in urethra daily until all sensitiveness disappeared. My opinion was that the constitutional disturbances and impotency were due to urethral hyperesthesia, brought about by sexual excesses. Accordingly, I introduced a Leroy bulbous bougie, down to the neck of bladder. At the latter point some tenderness was still present. No other abnormalities were discovered. Upon its withdrawal the usual membranous fold was detected four and a half (4½) inches from meatus. Up to this time my patient was improving, and we continued the treatment first ordered. He made a trip to the country, and upon his return informed me that he had a severe attack of RENAL COLIC, resulting in the escape from the urethra of numerous calculous concretions, which had aggravated his bladder and urethral trouble. Enclosed in a paper, was a specimen of a larger calculus. My friend, Prof. W. B. Hazard, who was present, pronounced them *oxalate of lime*. (A later chemical examination verified this statement). The presence of these concretions directed my attention to his INDIGESTION—which I had ascribed to reflex nervous troubles—and I prescribed five (5) drops of nitro-muriatic acid dilute thrice daily, to be gradually increased to toleration. I also injected bladder with a solution of one and a half (1½) drops of nitric acid pur. to two (2) ounces of water. This treatment had the desired effect. My patient soon recovered entirely.

It was a fortunate coincidence that a *large number* of these concretions passed with his urine; for he acknowledged the frequent presence of a sandy sediment previously, but had neglected to inform me of the fact. The symptoms pointed to either deep urethral hyperesthesia from sexual excesses, or to a vesical calculus. The former was verified, but the latter could not be discovered.

by the free use of the sound. Then again, STRicture OF LARGE CALIBRE (?) might be responsible for the same mischief, or at least a contracted meatus. The latter indeed existed, but not being an enthusiastic believer in the former view, I placed little stress upon it.

My object in reporting this case is to call attention to the fact, namely, that the oxalate of lime diathesis is more frequent than is generally supposed, and that it is often mistaken for some other obscure difficulties. Thus a prominent gentleman of this city, who had been a sufferer for some years, consulted a REPUTED NEUROLOGIST of New York city, who immediately diagnosed some serious nerve trouble. The patient returned to St. Louis, was placed upon an acidulated carbonic acid and beer diet, and soon recovered his health. In fact, a free perusal of medical literature fails to discover any distinctive discussion of this disease. Walter Coulson, F. R. C. S., England, and Prof. Austin Flint, are the only ones in which references could be found. It would be well for some of our authorities on genito-urinary subjects to devote more space to the description of such affections, which are so liable to be mistaken for other pathological conditions. PERI-NEPHRITIS, for instance, is another one of those renal difficulties which have not received sufficient attention. If I am not in error, Dr. Gibney, of New York, is the first who has directed our attention to the great resemblance it bears at times to the morbus coxarius, and yet none of our great orthopedic surgeons make reference to it. And yet, the disease exists and does simulate hip-joint disease greatly. At some future time I shall be pleased to present the profession with a more exhaustive view of both subjects.

IODOFORM AS A LOCAL APPLICATION IN FISsure OF THE ANUS.

BY THOMAS HAY, M. D.,
Of Philadelphia.

The value and efficacy of iodoform in fissure of the anus will bring this remedy into general use in the treatment of this painful and heretofore incurable lesion, without operation by the knife or forcible rupture of the sphincter ani muscle.

It is good surgical practice to cure surgical cases without surgical operation whenever it is safe and practicable; and while it is shorn of its brilliancy and eclat, the fact remains the same, and it is not questioned that conservatism in surgery has been steadily gaining ground, and that the boldest operators are those who weigh well the results before operating.

As in cases involving the greatest danger, so with fissure of the anus—if the trouble can be cured by simple means, without suffering to the patient, and in reasonably due time, the operation of cutting, or forcible rupture, is not justifiable, and both these means of radical cure must give way to the more simple, if such may exist. With the experience I have had in the use of the local application of iodoform in cases of fissure of the anus, I am encouraged to bring the value of this remedy to the notice of the profession in these cases. In their treatment with this remedy, the alvine evacuations should always be maintained in a soft condition; the bowels should never be allowed to become constipated or relaxed; the anus, and parts involved by the fissure, should be kept constantly clean and free from deposit and dry incrustations; and with one or two evacuations a day, the case may be speedily cured by the local use of iodoform. It may be dusted, in *very fine* powder, upon and into the fissured parts, or applied in the form of ointment or suppository. The application of the simple powders, if properly prepared, three or four times a day, after each evacuation, and in the intervals, is often sufficient. In some cases, however, the undiluted powder—although thoroughly powdered—causes some pain. In such, the iodoform may be mixed with powdered gum acacia, if a powder be preferred, or may be made into an ointment with vaseline, or suppository with the oil of theobroma. Balsam of Peru, carbolic acid, and oil of peppermint, will moderate the intensity of the iodoform odor; but this can hardly be requisite for application in this situation. The application of the remedy may be followed by a little smarting, but soon after its use the sensibility of the parts becomes benumbed, and even defecation may go on without consciousness, so far as concerns the development of pain during or after the process. That this remedy applied as above directed and indicated will cause complete unconsciousness of the act of defecation, I doubt—I have never witnessed such result in any case that has come under my notice, and still the numbing influence of the remedy is decidedly potent. As in applications to the conjunctival surfaces of the eyelids, the first and most important factor in the successful and painless use of the remedy consists in the proper preparation of the powder. It should be made *very fine*, and not the smallest crystal be allowed to remain unpowdered. The neglect of this precaution when applied to the eye has caused the most painful inflammation of the ocular and palpebral conjunctiva; and applied thus imperfectly

powdered to the anus, would likewise cause intense suffering, and as in eye practice, would be abandoned, and declared to be dangerous and valueless, if intelligence did not bring relief.

HOSPITAL REPORTS.

PHILADELPHIA HOSPITAL.—A CLINICAL CONFERENCE.

BY JOHN M. KEATING, M. D.

Reported by W. A. EDWARDS, M. D., Assistant to Professor Clinical Medical University of Pennsylvania.

The Rachitic Diathesis.

GENTLEMEN:—As has been my custom I propose to take up for your consideration to-day, one of the four diseases that are termed diathetic, those affecting the nutritive process, either from a constitutional, or an acquired taint, developing at times almost immediately after birth, because of the intensity of the inherited potent cause or again waiting for some future time when the infant shall be placed under circumstances adverse to its proper growth and development.

Rachitis or *Rickets* is a disease of the general nutritive process, attended with structural changes most conspicuous in the bones; this consists in an abnormal increase in the cartilaginous and embryonic substance of the osseous tissue.

As a rule rickets is noted no earlier than two or three months, and then its first manifestation is generally the nodules at the chondro-costal articulations, the so-called beaded ribs; after the age of two or three years the number of those affected with rickets become gradually less. Occasionally the disease is said to be congenital; such children die of atelectasis or of trismus. You have all heard of congenital *craniotubes*, and doubtless you have seen well marked examples of it at your clinics. This condition you know means an imperfect extension of the centres of ossification in the parietal and occipital bones, a want of the deposit of bony matter, as a result the cranial covering in places is like a mere membranous cap, jotted here and there only with islands of ossification. Of course a condition of this kind will not protect the delicate brain centres from external pressure and trismus will result.

It has been a question much discussed whether or not this condition is an unmistakable or invariable evidence of congenital syphilis, as some authorities claim, but I think that our experience warrants the statement that inherited syphilis, being also a disease of the general nutritive process, can by simply retarding development be in itself a cause of this form of rickets, and that independent of it, the rickety diathesis alone, when acquired *in utero* will act as an equally potent cause. I might even go further and state that the tubercular and scrofulous diathesis of ante-natal acquisition would give us the same result.

I have seen babes born of syphilitic mothers with *craniotubes* and I have also seen *craniotubes* in new born children, where no specific history could be found; a marked example of this oc-

curred during my term in this Hospital two years ago; one of a pair of colored twins died shortly after birth, of convulsions, and its skull presented the picture that I have just drawn for you. The other child lived and gave us an example of marked rickets, and if my memory serves me right, died of catarrhal pneumonia, a frequent complication of the rickety thorax. As to the cause of rickets independent of hereditary predisposition, the following present themselves as powerful determining influences; insufficient or improper food, faulty assimilation, residence in dark, damp, ill-ventilated places, exhausting diseases; all of these play their part, with the addition of that ever important state, the what is it of etiology, a tendency to the production of disease.

Various theories have been promulgated as to the production of rickets: one a deficiency of phosphates in the blood; the other an excess of acids, mainly lactic, which dissolve the phosphates, and thus allow them to be eliminated by the kidneys, instead of being deposited as alkaline lime salts in the bones; in other words, the osseous metamorphosis does not occur, the diploë of the flat bones enlarge, and the laminae separate more or less from each other, forming interlammellæ, which finally fill up with gelatinous fluid.

The consequence is that as the bone becomes curved, the periosteum relaxes on the concave side, and the deposit at that part becomes excessive.

There is increased vascularity of all the constituents of the bone; we find the periosteal, medullary, cortical, and cancellated structures congested, deeply reddened, and filled with this gelatinous transudation.

Gradually the laminae become thinner and more yielding, the bone becomes greater in its porosity, and when the new material is washed out, the weight of the bone is found to be less. Rokitansky tells us that if we boil the rickety bones, the result is unlike the chondrin or other animal matter of sound bony tissue.

The diaphyses and epiphyses of the long bones are separated by an increased mass of uniting cartilage, the ligaments become lengthened and relaxed, presenting the appearance designated "articuli duplicati," or double jointed: the bones most in use are earliest deformed.

The rachitic skull is generally described as square: it is usually flattened in all directions; the sutures late in closing are usually depressed; the thorax develops a lateral depression between the third and ninth ribs, owing to the action of the scapular and humular muscles, together with the force of atmospheric pressure. The sternum is forced forward and becomes prominent at or below the ninth rib.

The pelvis may also be greatly deformed; its upper portion may be expanded and the lower contracted; thus, in after life, seriously affecting the mechanism of labor, as we frequently see in our lying-in wards.

The teeth of rickety children are retarded: in practice, if the child does not present a tooth at twelve months, we generally regard it as pointing to a rickety diathesis; you will also usually find the fontanelles patent, especially the anterior, which will remain so until the twentieth month,

or even later. There is liability to perspiration about the neck and head—Jenner tells us that this is diagnostic of the disease; the urine is increased in amount; the bowels are variable, alternating between a condition of constipation and one of diarrhoea; hyperesthesia is sometimes a marked symptom. The lungs may be attacked by pneumonic, catarrhal or tubercular phthisis; the brain may be oedematous, or its ventricles may be filled with serum.

The bronchial and mesenteric glands are enlarged; the intestinal glands are also involved in the general dyscrasia; hence, we have as a prominent symptom, disordered nutrition, together with the consequent emaciation, wasting of the muscles, and loss of color.

The osteomalacia or malacosteon affecting women after child-birth, of which we see a number of examples in this house, bears a close relationship to the rickets of children; but the former is confined to adult life, while the latter is a disease peculiar to children. Malacosteon is also attended with severe pains.

Parents are always solicitous as to the *prognosis* of rickets. The result is the same as I have told you in all the diathetic diseases, if the inherited taint is not too overwhelming, our little patients will eventually practically recover, although the deformities of the disease still remain. This is especially so when the disease commences about the second year or later, and only affects two or three bones.

You must pay due regard to the condition of the gastro-intestinal tract as an important factor in making up your prognosis.

Unfortunately, in the major portion of your cases, you will not find the disease pursuing so favorable a course, and the little sufferer will perish either from exhaustion, bronchial or intestinal catarrh, or occasionally by an exanthemata as a complication.

In the *treatment* of these cases, your first thought should be as to their hygienic condition and surroundings; and see to it that these are as perfect as circumstances will permit.

Food next calls our attention. If the child is still nursing, experience will tell you that there is no food so well adapted to its use as the maternal milk, provided, of course, that the supply is sufficient and of proper quality, and that the mother is not a victim of any of the four diatheses about which I have told you so much during our visits to the wards. As the child grows older, its diet must still be uppermost in your plan of treatment.

We have no medicinal agent which acts as a specific in this disease (as you know iodine and mercury do in the syphilitic diatheses), but we must exhibit our drugs in order to meet special indications. Lime water meets the condition of the gastro-intestinal tract, and also supplies the bones with the needed material. A good plan is to give it with the milk. Cod-liver oil should be our sheet anchor to prevent emaciation. Give it either internally or by inunctions; the latter method you will find acts marvelously in these cases.

Iron, as the tinct. of the chloride, must also be supplied as an haemetic, and for its restraining property on the bowels.

Salt sea baths, among the rich, are good adjuvants to your general treatment.

Let us devote the balance of our time this afternoon to a study of some of the diseases of early infancy and their treatment, using as our text the abundant material which you see the wards present.

We will begin by studying *ophthalmia* and its forms, the *blepharitis* and the *catarrhal*.

This disease is more prevalent in asylums, and a glance around the ward will convince you that our hospital is not an exception to the rule. Want of cleanliness or *dirt* is a factor in its production; it occurs at times with puerperal fever; leucorrhœa or gonorrhœa in the mother may produce ophthalmia in the child; when produced by the latter it is perhaps the worst form of inflammation of the eye that you will be called upon to treat.

This little patient, who is suffering from simple catarrhal ophthalmia, illustrates well the disease as you will usually meet it. Note the bloodshot appearance of the eyes with soreness and pain; you notice that it turns its head as much as possible from the light. In the right eye, which is the most affected, you will please notice this irregular injection of the conjunctiva, which, unfortunately for the patient, is becoming general and velvet-like, with here and there a raising of the mucous membrane in spots like water blisters; this we technically designate *chemosis*. There is a mucous discharge which agglutinates the edges of the eyelids; this is more noticeable at night or upon arising. This is about the extent to which the catarrhal variety reaches, but not so in the blepharitis or purulent form; here the course is rapid, twenty-four to thirty-six hours.

This little lad presents us a typical case: here we perceive much swelling, the conjunctiva has assumed a deep red hue; you also note numerous fine granulations, occasionally flakes of pseudo-membrane; abundant creamy pus, at times tinged with blood, is poured out.

This is a very critical period, the dangers lying in the fact of the possibility of rapidly destructive ulceration of the cornea causing blindness, although it is possible for a considerable ulcer of the cornea to heal in a child, even without leaving an opaque cicatrix.

The treatment must be prompt and vigorous; the pus must frequently be removed by injections of warm water, which may be carbolated, or Smith recommends a solution of corrosive sublimate. We may use alum, grs. iij. to $\frac{3}{4}$ j.; Von Graeff uses a strong solution of argenti nitras. As very much depends upon the vital energy of the child's system, pay especial care as to its nourishment, bathing, and the state of its bowels.

The catarrhal variety, of course, does not require such active treatment.

It is well to start out by the administration of a saline cathartic. Here you may use a mild wash of nitrate of silver, one or two grains to the ounce, or some of the other mild astringent washes. If the disease remains rebellious, leeches back of the ear, or a blister applied to the temple, will materially aid in the cure. It is just as important here as in the severer forms of the disease, to keep the eyes clean; and I may add that great care should always be exercised in washing the eyes of the

new-born. As the subjects of these diseases are generally more or less cachectic, you will find it advantageous to place them on a general tonic treatment. The 25% to 50% emulsions of cod-liver oil, containing a certain proportion of the phosphate of iron dissolved in them, say one to two grains to teaspoonful, are valuable.

Then again, you will find, as I have so often told you, hygiene and a well-regulated diet to be your sheet anchor.

NEW YORK HOSPITAL.

CLINIC OF PROF. WILLIAM H. DRAPER.

Reported by W. H. SEELEY, A. M., M. D.

Pleuro-Pneumonia.

The patient was robust, strong-looking young man, with dark complexion. He was admitted to the hospital October 31. Age 24. Unmarried. A reporter. Drinks occasionally. Family history is negative. He gives no personal history. He has always been well until the 23d of October. He then felt sudden, sharp, darting pains in his right side, which extended to the lower part of the chest, and down toward the groin, and they were worse on coughing. He had not been unusually exposed to cold or wet before this, and knows no cause for it. He soon became feverish, and was obliged to take to his bed. He was treated by a physician outside of the hospital, and was relieved by the application of a fly blister. He has had no chill, and no urinary symptoms. Is suffering from anorexia. At the time of his admission his pulse was 120 per minute, respiration 40, temperature 104.8°, at twelve o'clock 103°; November 2, morning, temperature 102°, and evening 103°; November 3, morning, 103°, and now, at 4 p. m., it is 103.2°.

You observe, gentlemen, that the range of temperature has been pretty high since he came in and has been under observation, and it was probably high before and ever since the beginning. The high temperature at the time of his admission was probably due to disturbances caused by his removal to the hospital. It is a rule here to find a higher degree of temperature at the time of entrance than prevails on the following day; for the excitement of being moved, and the change, cause a temporary increase of the fever. So it was in the case of this man.

You notice that the expectoration is rusty in color, and this is due to the coloring matter of the blood; but it is not so viscid as we usually find it in pneumonia. It is more like what we get in bronchitis, but we usually have some bronchitis with pneumonia. I will now make the physical examination to see what more we can learn.

Auscultation.—On listening over the back of the chest, I find that he breathes with tolerable freedom, and the movement is almost symmetrical on both sides, or perhaps a little freer on the left. The vocal fremitus is more marked on the left than on the right.

Percussion.—When I percuss over the back of the chest from above downward, you observe that as I pass below the spine of the scapula on the right side, the percussion note becomes duller, and as I get a little lower it becomes absolutely dull. On the left side there is fair resonance, and

percussion with the flat of the hand makes the difference on the two sides more evident than does mediate percussion. In front, on the right side, dullness begins at about the same level as behind; but the line of dullness is altered by change of position, showing that there is fluid in the pleural cavity. But this is not an uncommon complication with pneumonia.

On auscultating again below the line of dullness on the right side, I find an absence of the respiratory murmur, and even during the forcible inspirations produced by coughing no air is heard to enter the lungs below this line. When auscultating and the respiratory sounds seem to be absent, it is important to ask the patient to cough, especially if it be a very feeble person, as this is often the only way by which you can introduce air into an apparently impervious lung. Sometimes the breathing is so extremely shallow that full inspirations are not taken, and the air does not seem to enter certain parts of the lungs, but the act of coughing shows that it does enter. While the vocal resonance in the upper part of the chest on the right side is normal, as we approach the line of percussion dullness we here get the peculiar sound known as egophony or a bleating bronchophony which indicates the presence of fluid.

Now, in this case, from the subjective symptoms and the objective examination, why would you suspect that there was something more here than simple pneumonia? It is because the fever chart shows that there has been no crisis, and the fever continues high although this is the twelfth day, while in pneumonia we get the crisis between the fifth and the eleventh day. One more important point remains to be determined here, and that is whether the fluid in the pleural cavity is serous or purulent. We can not infer positively that it is purulent because of the continued fever with its periodical exacerbations. But this question can be determined at once by introducing a needle and examining the fluid drawn off. This will be done here, and you will learn the result at the next meeting.

MEDICAL SOCIETIES.

PROCEEDINGS OF "THE COLLEGE OF PHYSICIANS OF PHILADELPHIA."

The History of a Case of Abdominal Cystic Tumor, where Seven Years after Removal of the Tumor by Laparotomy a Second Operation was Demanded: Tapping through the Vagina Resorted to, with Consequent Death of the Patient.

BY WALTER F. ATLEE, M. D.

[Read March 7, 1883.]

Bene facit qui ex erroribus suis exemplum aliis praebet.

In June, 1875, I removed, by laparotomy, in the St. Luke Hospital, Bethlehem, a multilocular cyst from Mrs. DeM.—. The history of the case was given by Dr. Stout to the Board of Trustees, and published in their second Annual Report. The whole mass removed at the operation weighed seventy-eight and a half pounds. The lobes and

lobules composing it were made up of cysts containing fluids of different densities, colors, and other physical properties. The pedicle appeared to arise from the rectum; at all events, the cyst wall was separated from everything else, except the front of that intestine, and the only ligature used was there applied. The whole vascular supply was derived from meso-rectal vessels. Of course, the clamp could not be used. As always, in sewing up the incision in the abdominal walls, I carefully included the peritoneum in the sutures, as in this way adhesions of intestine and omentum, with the consequent discomfort and constipation suffered by the patient, are never observed, and, moreover, in case a second ovariotomy should have to be performed, the operation could be performed with much more ease and safety.

This patient recovered from the operation, though somewhat slowly, owing to delay and difficulty in removing the ligature, which was left hanging out of the external wound, and not cut short and left inside the abdomen, as is now generally practiced. She remained in perfect health for seven years, but in the summer of 1882 came to my office complaining of considerable discomfort in the pelvis, where I detected, by the touch, the presence of a swelling, caused by a thick, viscid fluid; in other words, there was plainly a second tumor formed there. This continued to enlarge, and in the month of January the suffering it occasioned was so immediately threatening to the patient's life, that it was necessary to act. Great efforts were made to push the tumor out of the pelvis, but this was not to be accomplished. It remained to operate as before, and remove the mass by laparotomy, or to give relief by emptying the cyst by tapping through the vagina. The latter procedure was preferred, and about three pints of a very thick, dark-colored fluid were drawn off by a Thompson trocar. There was no difficulty about the operation, nor was it attended by any particular pain, nor was there any hemorrhage. The next day the patient felt herself completely relieved, but after that her pulse became quickened, and a general febrile condition, unpreceded by chill, succeeded. There was evident tenderness on pressure over the lower part of the abdomen, but no severe pain independent of this pressure. The stomach became so irritable as to reject everything swallowed. Death took place on the eighth day, under the marked symptoms of depression which accompany pyæmia. It was a death, most plainly, from cyst inflammation.

Notwithstanding the great number of cases of operation for ovarian disease reported nowadays in journals, more or less medical, this case is really one deserving of record, and one of true and special interest to the pathologist and to the surgeon.

In removing the large mass in the first operation, in this case, it was noticed that no pedicle was found. It was separable by the fingers everywhere except from the front of the rectum, where it was necessary to apply a ligature and divide the attachment by scissors. The ovaries, as we all know, are situated in the posterior fold of the broad ligaments, on the sides of the highest part of the uterus, behind the Fallopian tubes, and the round ligaments which separate them from the bladder, and in front of the rectum, from

which they are commonly separated by the lowest circumvolutions of the ilium. By a rounded cord, the ligament of the ovary, they are attached internally to the womb, and externally by two folds of the peritoneum to the sides of the pelvis.

As the ovary, in its normal condition, is not pediculated, at first, of course, a diseased ovary has no true pedicle. As it becomes larger, this pedicle is formed from changes in its normal connections with the adjacent womb; it consists of the Fallopian tube often much elongated, the broad ligament often considerably thickened, the utero-ovarian ligament occasionally hypertrophied to a large fibroid stem, the round ligament, and enlarged blood-vessels. If the tumor rises out of the pelvis, the pedicle will be longer, and if bound down in the pelvis from early adhesions it will be shorter.

In some cases, however, and they are by no means rare ones, when cystic tumors are removed from the abdominal cavity, no such pedicle as the one just described is met with. In the case, whose history I have been relating, it was said that there was no distinct pedicle, and that the whole vascular supply came from the vessels of the meso-rectum. It may naturally be supposed that this was owing to the way in which the diseased mass may have been separated from its surroundings, and I therefore call attention to the fact that the same thing has occurred in the practice of an operator such as Spencer Wells. In his *Diseases of the Ovaries*, in relating Case CX., he says that he found no pedicle, and that the tumor derived its vascular supply from the omental and mesenteric vessels.

It seems to me most reasonable to look upon some of the abdominal tumors having these connections, not as enlarged and diseased ovaries, but as changed ovules, which have failed to enter the Fallopian tubes, have slipped into the interstices of the neighboring organs, become attached, received blood, and grown. In women, when the Fallopian tube has become adherent, in place of floating loosely, the ovule is not grasped as it leaves the ovary, and then it is not rare to see ten, fifteen, twenty, or even more small cysts, some as large as a pea, on the parts immediately in contact with the ovary. (See Sappey, vol. iii., p. 644.)

If one of these misplaced ovules was attached to a spot, where plenty of blood was supplied, a large cyst could be formed, having no distinct pedicle, as in the case before us. As is seen in cases of extra-uterine foetation, a well-made child can be formed in this way from a fecundated ovule, and we may suppose that from an unfecundated one a monstrous polycystic growth should form.

Although out of the way, I wish to mention here that the only two cases in which I have been consulted on account of a return of abdominal cystic tumors, were where there was no pedicle, and where the chief vascular supply came from the vessels in front of the rectum. One case is the one now under consideration, and the other is the one published in the *American Journal of Medical Sciences* for January, 1883, on account of the bladder having been opened during the operation.

My reason for reporting this case, however, is not to advance any particular views in regard to

the pathology of certain polycystic tumors of the abdominal cavity, but in order to speak of the mistake made in the treatment. In the words of one who has done as much as any other to advance our knowledge of the treatment of abdominal tumors : "Mistakes teach most valuable lessons, and, when discovered, are not likely to be repeated. Hence, in medicine, they should be recorded for the benefit of science and of humanity." (*General and Differential Diagnosis of Ovarian Tumors*, by Washington L. Atlee, in Preface.) When this case presented itself, it was necessary to act ; a speedy and most painful death was inevitable, unless relief were afforded. It remained to choose between the removal of the cyst and the emptying of its contents by tapping through the vagina, the only way practicable of introducing a trocar. On account of the operation previously performed, and the impossibility of moving the mass in the pelvis, its removal was not attempted. A previous operation is not necessarily an objection ; Dr. Washington L. Atlee records two cases where a second operation was performed, and in both successfully. Spencer Wells, in his table, gives thirteen cases in which he removed an abdominal tumor from a patient who had previously undergone the operation, and eleven of them were successful. Here, however, the immovability of the tumor was such as to make me positively sure that the attachments were so great as to render its removal impossible.

Of tapping through the vagina I had no personal experience whatever, and what is recorded by others, although not, as a general rule, favorable to the plan, did not deter me from it. Scanzoni goes so far as to say that if puncture by the vagina was always possible, abdominal puncture would soon completely disappear from surgical practice. The sac, opened in its lowest part, can empty itself more completely. (Scanzoni, *Traité pratique des Maladies des Organes sexuels de la Femme*, Paris, 1858.) Peaslee says that there are three considerations to deter us from it in all ordinary circumstances : 1. The vessels are larger and more numerous at the lowest part of the tumor. 2. If polycystic, the largest cysts are not at its lowest part. 3. There is greater risk of wounding other organs. (Peaslee, *Ovarian Tumors, their Pathology, Diagnosis, and Treatment, especially by Ovariotomy*, 1872.)

Emmet writes that he has punctured several cysts with a trocar from the vagina, and in every instance more or less cellulitis has resulted. This might, however, destroy the cysts, but he is not able to determine that, for all the cases passed from under his observation. (Emmet, *Principles and Practice of Gynecology*, 1880.)

Thomas says that by this method two of the dangers of tapping, secondary escape of fluid into the peritoneum, and consequent peritonitis, are unquestionably avoided, but others are as surely increased, namely, those of injury to portions of the intestine and entrance of air into the sac, with consequent decomposition of the contents, septicæmia, and inflammation of the sac walls. His experience with the method is not large, but it leads him to agree with Spencer Wells. (Thomas, *Diseases of Women*, 1872.)

Spencer Wells says that tapping through the vagina is more liable to be followed by inflamma-

tion of the cyst than tapping through the abdominal wall, because it is not easy to prevent the entrance of air. The operation of tapping through the vagina is selected, not so much with the intention of simply emptying the cyst, as for the chance that should the fluid escape by the opening, as fast as it is secreted, the cyst may gradually contract, and the puncture close. This favorable result, however, is seldom secured. As a rule, air enters the cyst, the opening fills up, the fluid remaining in the cyst, or that newly secreted putrifies. Suppurative inflammation of the lining membrane of the cyst comes on, and is accompanied by a low form of septic fever or pyæmias, which can only be relieved by making and maintaining a free outlet for the discharge. The frequency of these consequences should make tapping by the vagina an exceptionable practice, but it may be adopted in cases where an ovarian cyst is bound down in the pelvis by adhesions, and it is necessary to relieve the distress caused by pressure on the bladder and rectum.

The canula or an elastic catheter may be left in the cyst, though it is safer practice either to introduce a wire seton or a drainage tube, so as to prevent the opening from closing, and make sure of the free and immediate escape of any fluid that may be secreted. Even with every care, however, Mr. Wells concludes, from his experience, that patients are so apt to suffer from some of the ill effects of long-continued suppurative processes, that it is better, even at considerable risk, to remove a cyst, if at all possible, than to trust to any mode of drainage. (Spencer Wells, *On Ovarian and Uterine Tumors, their Diagnosis and Treatment*, 1882.)

Dr. Charles West, whose opinions have for me, at least, extraordinary importance, greater indeed on such a point than those of any other man, says that there is no doubt but that inflammation attacking parts within the pelvic cavity is less apt to extend to the peritoneum than when it attacks an abdominal organ ; of which rule pelvic cellulitis and inflammation of parts within the folds of the broad ligaments are apt illustrations. It is equally incontestable that pelvic peritonitis is less apt to become generalized than is similar mischief originating in the abdomen. Cyst inflammation is so dangerous, however, that it is doubtful if vaginal tapping may be employed, even when the cyst is simple. Its dangers are incalculable. The dangers of ovariotomy are far less. Except when a cyst is impacted in the pelvic cavity, he does not recommend tapping per vaginam. (West, *Lectures on Diseases of Women*, 1879.)

Our best authorities, therefore, teach us that the tapping of polycystic tumors at least must be avoided ; that the removal of the cyst is to be practiced in preference ; that when impacted in the pelvis, so that it interferes with the performance of functions absolutely necessary to life, tapping, to which we must have recourse, is particularly dangerous, owing to the frequency of cystic inflammation, and consequent death from septicæmia. In my case I thought to avoid this by taking precautions to hinder the entrance of air into the cyst, but it took place notwithstanding, and the death of the patient was occasioned by it in eight days.

If, unhappily, I should ever again be called upon to try to relieve a similar case, I should act differently, and, not relying upon any means to prevent the setting up of cystic inflammation, do more to establish a free outlet for the noxious products by which the system is poisoned, and do everything in my power to prevent their formation by topical applications to the secreting surfaces of the cyst.

Dr. Noegegerath (*Ovariocentesis Vaginalis, American Journal of Obstetrics*, May, 1869), by pursuing this course, had such good results as to declare himself confident that, where a simple or compound cyst could be attacked through the posterior vaginal cul-de-sac, this operation would take the place of laparotomy. The plan he prefers is to make first a transverse incision, about an inch long, behind the cervix uteri and through the roof of the vagina up to the cyst. This, coming into view, is then evacuated by a free incision, and, finally, the edges of the two incisions are stitched together by five or six silver sutures. The cyst thus left free and permanently open is daily washed out with antiseptic injections until it finally contracts, and ceases to afford any secretion. Although, at the present time, it is not likely that in ordinary cases any one would choose to perform this operation to that of the removal of the cyst, yet all experience shows that when the cyst is so firmly fixed in the pelvis as not to be removable, it diminishes in a marked degree the great danger necessarily incurred by tapping through the vagina—that of poisoning of the system by the absorption of the putrid products of cystic inflammation.

I feel certain myself that I made a sad mistake in not operating in this way, and report this case, as a warning to others—*Bene facit qui ex erroribus aliorum, sibi exemplum sumat.*

[After the reading of the preceding paper:—] Dr. William Goodell said that he did not think the attachment of the tumor to the rectum was so unique as the return of the tumor. He had on several occasions removed tumors without being able to find the true pedicle, on account of the many adhesions. He could not agree with Dr. Atlee with regard to the origin of the cyst—he did not think it could have come from a wandering ovum, since, in that case, it would have been monocytic.

He regarded tapping per vaginam hazardous, for the reasons given by the late Dr. Peaslee, first, on account of the danger of wounding blood-vessels, and second, on account of the danger arising from the entrance of air into the cyst. He did not understand why the air could enter the cyst so readily after tapping per vaginam. When he performed tapping by this method he employed the aspirator. Returning to the question of the attachment apparently of the pedicle to the rectum, in the case reported, he said that it was quite common not to find a pedicle in some forms of intra-ligamentous cyst, because they had to be enucleated, and referred to the statements of Lawson Tait with regard to this difficulty of determining the origin of the tumor. He desired to call attention to the pathological characters of the recurrent growths, and stated that according to his observation they were always malignant, and that they recur in the stump of the pedicle, or, as he

had seen, at the site of the adhesions. He alluded to a case which occurred in his own practice, and to one related to him by Dr. Bantock, of London, which confirmed the statements made.

He asked Dr. Atlee whether he could explain why the air entered so readily into cysts after tapping per vaginam.

Dr. Atlee, in reply, said that he had seen no reason given, but thought it was owing to the difficulty in closing the wound made in the tapping.

Dr. R. P. Harris remarked that perhaps he could throw some light upon the cause of this admission of air, from what he had observed in a case of removal of hemorrhoids. Some years ago, soon after the introduction of the écraseur of Chassaignac, he called in the late Dr. Joseph Pancoast, who had obtained the instrument, to make use of it in removing a mass of hemorrhoids from the rectum of a very anæmic man, rendered such by repeated hemorrhages after defecation. After the operation, to prevent, as he stated, the suction power of the diaphragm upon the rectum, endangering secondary hemorrhage, Dr. Pancoast introduced into the anus a small box-wood tube. The effect of this was soon demonstrated: a large drop of serous fluid descended the tube and stopped at its exit; when the diaphragm arose in expiration, the drop was drawn up the tube, and when it descended in inspiration, it came down again; thus showing the pumping effect of the diaphragm upon the pelvic contents. Let this open tube become an opened cyst with flaccid walls, and we have air pumped into the cyst, as it was into the rectum of our patient.

Dr. J. Ewing Mears asked Dr. Atlee whether a post-mortem examination had been made. He thought the observations of Dr. Goodell with regard to the difficulty of finding the true pedicle in tumors with many adhesions, and to the pathological characters of the recurring tumor in these cases, to be correct, as such had been his experience in instances of which he had had personal knowledge. With regard to the entrance of air into the cyst, when tapping is performed per vaginam, he thought the explanations of Drs. Atlee and Harris were correct. A cyst firmly impacted in the pelvic cavity is separated from the vaginal tube by a comparatively thin septum, differing greatly in its anatomical characters from the abdominal wall. The opening made by the trocar in this septum and in the cyst wall attached to it by adhesions, does not close perfectly, and the air drawn up into the vaginal tube passes readily into the collapsed cyst.

Dr. Atlee, in reply to Dr. Mears, stated that no post-mortem examination had been made.

Consumption of Tobacco.

According to *Les Mondes*, it appears that in Russia, France, and England, the consumption amounts to one pound per inhabitant. In Italy it is rather higher, one and a half pounds. Austria comes next with two and two-fifths pounds. In the United States and Germany the consumption amounts to three pounds, in Belgium to four and four-fifths pounds, while Holland has the privilege of heading the list with a consumption per inhabitant of more than five and a half pounds.

EDITORIAL DEPARTMENT.

PERISCOPE.

Certain Proof of the So-Called Uterine Milk in Man.

The *Edinburgh Medical Journal*, February, 1883, says: Under this title G. Von Hoffmann contributes an interesting article to the subject of placental physiology to the *Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. viii. Heft 2, S. 258. The author supports the views of those who, like Ercoleiani, maintain that even in the human species the placental villi do not project freely into blood-spaces in the maternal part of the placenta, but are always covered with the milk-secreting organ, which is developed in the upper layers of the serotinal decidua during pregnancy. The sinus system, as it is called in the human subject, is, according to our author, made up of this milk-secreting organ. But in consequence of the dilatation of its walls in the course of development, some maternal capillaries become thinned and burst, so that permanent lacunae are formed, through which maternal blood enters the sinus and mixes with the uterine milk secreted from its walls, which are, of course, made up of altered decidual surface. This maternal blood and uterine milk is absorbed by the fetal villus for the nourishment of the fetus. The method adopted by the author to prove his theme is not so much an anatomical as a physiological one. He provided himself with fine capillary lymph-tubes. Then, laying the fresh placenta flat, with the maternal aspect upwards, and wiping its surface very carefully with a sponge, he introduced these tubes, some obliquely, some perpendicularly, to a distance of from 1 to 1½ centimetre. The intention was that these tubes should penetrate the placental tissue so as to pass between the fetal villi and pierce the intervillar spaces, extracting from the latter part of their contents by capillary attraction. In this way the author made observations on forty fresh placentas obtained at the end of pregnancy, and on those obtained from many abortions at various months. He found the fluid thus obtained consisted of—1. Red blood-corpuscles of various sizes and forms. 2. Colorless blood-corpuscles, somewhat larger than usual, but not in large quantity, being only about 1 or 2 white in 100 or 200 red corpuscles. 3. Uterine milk-cells. These occupied by far the greatest amount of space, and his view of their nature he supports by comparison with the fluid found in the cow's placenta. 4. Free intercellular fluid, clear as water. Less constant constituents of this fluid were—5. Decidual cells, floating freely, with nuclei and nucleoli. 6. Small round bodies, probably derived from red blood-corpuscles. 7. Small particles, or detritus, often colored red. 8. High-colored pigment-cells. 9. Certain irregularly formed azure-blue bodies. The fluid obtained in this way, on being collected in quantity and allowed to stand in a small test-tube, separated constantly into two layers, the upper layer

being invariably formed of the uterine milk mixed with blood-serum, the lower consisting essentially of red blood-corpuscles. The author compares the fluid thus obtained from the human placenta with that obtained from the cow's placenta, and finds that the elements he ascribes to the uterine milk are essentially the same in both, but that in the human placenta a considerable amount of blood is mixed with the milk, whereas in the cow scarcely any blood-cells are found. The author's results are finally formulated by him in the following propositions: 1. The destiny of the decidua in general in animals, as well as also specially in man, is that of affording to the fetus, during its intra-uterine life, a portion of the nourishment necessary to its growth. For the fulfilment of this task the serotina or decidua placentalis is transformed into a special milk-secreting organ, which is thrown off after delivery along with the placenta as an integral portion thereof. 2. The secretion of this organ, the so-called uterine milk, is secreted into the gradually-formed spaces in which the placental villi are situated. Here the uterine milk is commingled with the contemporaneously extravasated maternal blood, and, taken along with the latter, represents the fetal nourishment which only now appears suited for being absorbed by the fetal villi. 3. From the standpoint of comparative anatomy, the view of an essential difference between the placenta of the higher orders of animals and man is no longer tenable in the sense hitherto accepted, according to which an entirely separate position has been assigned to the human placenta in the scale of development. The author postpones for a future work the consideration of how the absorption of the fetal nourishment by the villi takes place, as well as other matters therewith connected.

Carbolic Acid Injections in Hydrocele, Ranula, and Cystic Tumors.

Dr. P. E. Sandidge thus writes in the *American Practitioner*, February, 1883: The purpose of the present paper is to give an account of a few cases of hydrocele, ranula, and analogous tumors, which I have treated in the last dozen years by injections of carbolic acid.

In March, 1868, I saw Mr. W. with my late lamented friend, Dr. J. W. Beauchamp, sr. The case was one of double hydrocele. Being led to think of carbolic acid as a probable cure for hydrocele by reason of what I had witnessed of its effects, in the year or two preceding, in promoting the healing of wounds, I suggested its use as an injection in this case instead of the tincture of iodine, or port wine, etc.; but, Dr. B. objecting, I emptied the sacs and threw in the tincture of iodine after the usual manner. The patient did well, and the operation seemed to be a success.

Two years later the vaginal tunic again began to distend, and in April, 1871, I was called to operate a second time. The tunic of the right side was greatly distended with a dark-looking

fluid, which I drew off with an ordinary trocar and canula, and injected two or three drachms of a solution of Calvert's carbolic acid No. 5, one part of water to three of acid. I manipulated the walls of the sac in such a manner as to bring the solution in contact with their every part, and then slowly pressed it out. The contents of the left tunic were clear. Having withdrawn them through the canula, I threw in two drachms of tincture of iodine, kneaded the parts, and withdrew the injection as on the right side. Two hours later the patient suffered intense pain and heat, with retraction of the testicle of the right side. The scrotum was much swollen and red, and the penis became erect. Rigors soon followed, and these in turn were followed by fever. The left side underwent no change. A brisk purge or two, rest in bed, low diet, and cold lotions to the inflamed parts, straightened matters, and in ten days the case was dismissed. The right testicle remained for a time somewhat retracted, and the scrotum on that side considerably corrugated. There were no marks of trouble on the left side.

Nine months after (January, 1872), the left tunic had refilled. The right was cured. I emptied the sac, injected carbolic acid solution, and got a speedy cure. The patient, now alive, has never had the slightest return of his complaint.

Mr. H., a farmer, thirty-five years old, who had a hydrocele succeeding upon an attack of abscess of the epididymis, was cured by a single injection of carbolic acid. The patient died six years after with consumption, without having had a return of his hydrocele.

From April, 1871, I have treated a considerable number of cases of hydrocele by the simple method here mentioned, with uniform success. I have not had to use the injection more than once in a single case. It has also come in my way to relieve a number of subcutaneous cystic tumors by the same means. I have had equal success with carbolic-acid injections in the treatment of ranula. The following report of a case may be interesting:

In November, 1876, I saw, with a medical friend, a girl thirteen years old, otherwise in good health, having the largest ranula I had ever met with. It positively hung under her chin like the pouch of a pelican. It pressed the tongue up against the roof of the mouth, interfering with articulation, deglutition, and respiration. Here, as in the first case of hydrocele I mentioned, I yielded to the wishes of my medical friend, and operated in the usual way, using tincture of iodine as the irritant. The following April the sac was more distended than ever before. I at once withdrew the fluid through a canula introduced at the most dependent portion of the tumor, and injected six ounces of Calvert's solution of carbolic acid No. 7, and took care to bring it in contact with every part of the cyst before it was withdrawn. The parts quickly became red and intensely painful. Rest in bed was enjoined, cold applications with moderate pressure were made to the parts, and a saline purgative given. Nothing further untoward occurred, and the sac has never refilled.

I have treated two cases of ranula since that time by the same method, with like success.

Adherent Placenta, Retained for Years, Simulating Cancer.

Dr. George F. French, of Minneapolis, Minn., reports the following case in the *Northwestern Lancet*, March 15, 1883.

Mrs. A., at 42, mother of twelve children, has always had profuse menstruation. Four years ago had twins; the placenta was adherent, and had to be detached by force. The attending physician thinks he must have left a considerable portion of it. Since that time the menorrhagia has increased. Two years ago the patient was delivered of her last child, since which time there has been a more or less constant flow or dribble. For two months it has at times been alarming, and on several cases the attending physician found it necessary to tampon. The patient came under my care the 1st of December. I found her blanched from loss of blood, sallow, and very weak. She could not assume the upright position without fainting. Mingled with the blood which was escaping from the uterine cavity, there was much watery and foul-smelling purulent discharge.

Digitio-vaginal examination threw no light on the case. No tumor was to be felt; the uterus was neither enlarged nor fixed, but the os so patulous that dilatation was unnecessary. I had hoped to find myself dealing with merely a granular degeneration of the mucous membrane, but the foulness of the discharge and the exhausted state of the patient made me apprehend grounds for the existence of some cancerous affection as the attending physician had intimated. On the other hand, the complete absence of pain, and the mobility of the uterus, as well as its small size, were grounds for hopefulness. On exploring the uterine cavity, I at once eliminated the possibility of any pedunculated tumor being present, and in order to arrest the hemorrhage, which was still unabated, and to throw greater light on the further diagnosis of the case, I scraped over the surface of the entire uterine cavity with a Sims' curette. The instrument did not meet with the usual resistance common to cases of granular polypoid degeneration (in such cases you can both feel and hear the resistance offered by the underlying muscular surface), but I brought away a pulpy substance, which, under the microscope, Dr. Hunter discovered to be *placental tissue*. The operation was followed by a severe chill, and the temperature on the next day was 104°. This disturbance of the system, however, was very brief, and in forty-eight hours had entirely disappeared. There has not been the slightest return of hemorrhage, and no pain attended or followed the operation. The patient eats and sleeps well, and there is no longer any doubt of a speedy and complete recovery.

Stenosis of the Trachea and Bronchial Tubes, with Amyloid Change in their Walls.

Dr. W. Balser* contributes an article with the above title. The case occurred in 1877. Nineteen years previously, the patient, then 45 years of age, consulted his physician, who found considerable consolidation in the upper lobe of the right lung, especially anteriorly. One year later

* Virchow's Archiv., Bd. xci., H. 1.

a severe bronchitis manifested itself, and five years later asthmatic trouble. In the latter years of life, the signs of bronchial stenosis appeared, which, in the last half year of life, reached their maximum, but never was there any abrupt change for the worse noted. The voice was not much affected except in the latter years, and complete hoarseness was never present. The chronic pneumonic process, together with an increase in the stenosis, accompanied by general emaciation and anaemia, progressed until death. At the post-mortem examination, the mitral and aortic valves were found diseased, and there were atheromatous changes in the aorta, but the chief interest attends the pulmonary organs. The larynx was strongly ossified, the trachea and bronchi formed stiff, scarcely flexible tubes, and their mucous membrane was greatly congested, and covered with gray-red mucus. Besides the extraordinary rigidity of the trachea and its ramifications, the trachea was compressed flat from side to side. The tracheal wall was very thick, and nowhere was the mucous membrane of it or the bronchi in a normal condition. In its superficial layers it was puffy, pitted, and granulated, in reality composed of several components, partly whitish or bluish cicatrical tissue, partly copious yellowish-red gelatinous masses, and some reddish, and in places dark-red colloid granulations. At the same time there appeared in the mucous membrane, especially in the lower parts of the bronchial tubes, numerous small bony rings. At the bifurcation of the trachea, the calibre of the bronchi was so narrowed as to scarcely permit the entrance of the tip of a little finger. The lungs were large and emphysematous. Numerous patches of induration were visible, and evidences of peribronchitis. A very thorough microscopic examination of parts of the trachea and bronchi revealed extensive amyloid changes, sections without previous hardening being possible on account of the extensive calcification of the walls. He believes that either with or after a chronic bronchitis with consolidation, an echondrosis trachealis multiplex developed, and upon the first the amyloid and other changes in the trachea were dependent.

Rare Sequelae of Enteric Fever.

From the *Medical Times and Gazette*, January 27, 1883, we learn that in the *Wiener Med. Woch.*, No. 50, Max Weiss has put on record a case of abscess of the brain occurring in connection with typhoid fever; and further, since gross lesions of the cerebrum in this disease are very infrequent, Max Weiss has prefaced the description of his case with notes of the literature of the subject. Griesinger, out of 118 cases of enteric fever, met with four instances of effusion of blood between the arachnoid and dura mater (there was no pachymeningitis, which is one of the most frequent causes of hemorrhage in this site); in two this happened in the third week of illness, in two in the marasmus after the disease had ceased. Buhl, out of 300 cases, met with two of softening with capillary hemorrhage in the substance of the brain. Tommaso Galli has communicated an instance of aphasia occurring in the course of convalescence. Berger has recorded a case of left

hemiplegia, which set in suddenly, with only transient disturbance of consciousness in the course of the disease. Duchek has contributed three examples which were observed in an epidemic characterized by little diarrhoea and abundant rash. In these individuals the symptoms were those of irritation and paralysis combined. Thus, spasm of the face, with lockjaw and stiffness of neck, back, and extremities, were mingled with ptosis, dilatation of pupil, and convergent squint (the third and sixth cranial nerves being paralyzed); one case showed cutaneous hyperesthesia, and another aphasia. The above reports are interesting, but, in the matter of diagnosis of gross cerebral lesion, evidence other than that obtained at the post-mortem table is apt to be misleading, and cannot be trusted—e. g., the symptoms of cerebral tumor are often observed in cases of renal disease. The case recorded by Max Weiss was that of a single woman, aged twenty-one years, who, six days before death, was suddenly seized with vertigo, after which the left side was found to be paralyzed. In the progress of the illness the left limbs were also the seat of clonic and tonic spasm. At the post-mortem examination there was discovered an abscess in the "motor" region of the right cerebral hemisphere; in the ileum, signs of a past enteric fever in the form of small, flat, shallow scars; and perimetritis, with catarrh of the uterus and Fallopian tubes.

Secondary Puerperal Hemorrhage.

Dr. Paul F. Mundé read a very valuable paper on this subject before the New York Academy of Medicine (*Med. Record*, January 27, 1883). He refers principally to the fact that alarming uterine hemorrhage may occur as late as several weeks after confinement, and concluded his paper by making reference to the means of preventing these hemorrhages, both primary and secondary. The following rules were given for the management of the third stage of labor and the early puerperal state:

1. Always keep the hand on the fundus uteri from the moment the head appears at the vulva until the placenta is expelled.
2. Do not hasten the expulsion of the placenta too much.
3. Always watch the uterus with the hand, using gentle friction occasionally, for at least one hour.
4. Always give ergot by the mouth immediately after the birth of the child. If chloroform has been given, or if the labor has been unusually tedious, give ergot hypodermically, injecting a syringeful of the fluid extract to the depth of one inch near the umbilicus.
5. If the uterus shows a reluctance to remain contracted, rub the fundus gently with a piece of ice, or insert a cone-shaped piece into the cavity.
6. Always make sure by palpation and percussion that the uterus contains no coaguli.
7. Apply the child to the breast early.
8. Apply an equally tight binder, and, if there be tendency to hemorrhage, a pad should be placed over the fundus to secure its steady compression.
9. If there be laceration of the cervix or vagina,

future oozing may be checked by mild astringent injections, or, if need be, by applications through the speculum. Immediate suture for laceration of the cervix appeared to him to be rarely feasible.

10. Do not allow the lying-in woman to leave her bed before the tenth day.

11. See that the bladder is empty, and is not interfering with uterine contraction.

12. See that the nozzle of the syringe is not introduced too far, and that too much force is not used in giving the customary cleansing injection.

The Cutaneous Manifestations of Paludism.

The *New York Med. Jour.*, March 17, 1883, says: In a paper on this subject by Verneuil and Merklen (*Ann. de Dermat. et de Syphil.*, Nov., 1882), the following are the conclusions arrived at:

1. Herpes is one of the common manifestations of malarial disease.

2. It may either precede the paroxysm of intermittent, or occur during any one of the three stages of the paroxysm, or it may follow the stage of sweating. It may appear even after the paroxysms of the fever have been suppressed by means of sulphate of quinine. There is no etiological connection between the herpes and the fever, notwithstanding their frequent coincidence.

3. Paludic herpes does not present any peculiar features. Its most common locations are the face, the region about the lips and nostrils, the eyelids, the cornea, and such points as are most abundantly supplied with nerves. Though ordinarily discrete, in certain epidemics the eruption presents a remarkable tendency to confluence.

4. Black crusts, or, more especially, black vesicles attending the herpes, pertain to grave and pernicious forms of malarial fever.

5. Exceptionally, the herpes of malaria takes the form of zoster.

6. The ordinary forms of malarial herpes may be preceded by and accompanied with vaso-motor disturbances upon the surface of the skin, and disorders of sensibility.

It is believed, in consideration of the habitual locations of the eruption, of its concomitant disorders, of its possible appearance in the absence of a febrile attack, that the cause of the disease is referable to a nervous lesion, perhaps to a congestion of the cutaneous nerve-branches, resulting from the localization of the malarial poison in these nerves.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—In the April number of *Lippincott's Magazine* one of the most striking papers is on "The Climate Cure," by Frank D. Y. Carpenter, who writes in a decidedly cynical vein, and who seems occasionally to overstate the argument against the claims of our principal health resorts, but who

dispels some common illusions, and depicts very forcibly and graphically their mischievous tendencies and results.

—The annual address before the New York Medico-Chirurgical Society by its President, Dr. E. P. Fowler, is very neat in typography and conservative and sensible in its contents. It discusses the meaning of such words as "disease," "cure," "recovery," etc., and has a few trenchant paragraphs on homeopathy.

—An odd and wild sort of a paper is one by Dr. Matthew Kempf, of Ferdinand, Ind., on the "Wandering Cainidae," a supposed ancient nomadic race. It is a lecture delivered before the medical society of Dubois county, and is half prose and half quotations from a poem apparently unpublished.

—Dr. John G. Lee, of this city, has written an interesting essay on "Homicide and Suicide in Philadelphia from 1871 to 1881." It is a thoughtful presentation of the influences which lead to these two great crimes. Suicide is not on the increase in this city, and the author very properly draws the line between the act as deliberative and insane.

—Dr. John Homans, of Boston, furnishes 100 cases of antiseptic ovariotomy. The net result is 87 recoveries, 13 deaths. He adds: "This is about as well as I can do, unless I refuse the desperate cases." Well enough, too, we think, when we remember that only twenty years ago this operation was condemned by many leading physicians as wholly unjustifiable!

—"The Electric Light in Surgical Diagnosis," is the title of a valuable reprint by Dr. Roswell Park of Chicago. He believes that these various "scopes" are "capable of aiding us to a realistic knowledge of many diseased conditions to which we could not otherwise attain." The same writer has published an essay on "Secondary Batteries and the so-called Storage of Electricity," well worth reading by all who are studying this important topic.

BOOK NOTICES.

The Dispensatory of the United States of America.

Fifteenth edition. Edited by H. C. Wood, M. D., Joseph P. Remington, Ph. G., and Samuel P. Sadler, Ph. D., F. C. S., etc., Philadelphia. J. B. Lippincott & Co., 1883, pp. 1,928.

In the heavy task of revising and, in fact, largely rewriting the United States Dispensatory, its editors have been engaged closely for the last

three years. The changes they have introduced are numerous, some of them radical. All, however, are no doubt the result of careful consideration of the needs of the time.

Of these changes we may note as of major importance that Parts I. and II. of former editions are now united as Part I.; that a number of original illustrations, largely of microscopic work, have been inserted; that a complete list of the analyses of American mineral springs is added, and that the index has been largely increased. The mineral waters are indexed separately, but no index of diseases is made out, which is an omission to be regretted.

The most material alterations in which physicians are interested, are in the sections treating of the medical properties and uses of drugs, etc. These have been recast by Prof. H. C. Wood, in sympathy with his well-known theories, that therapeutics should be based on physiology, rather than on bedside observation. That such a pronounced advocate of what is, at least, a debatable theory, should have had the charge of a work of this general scope, may, perhaps, detract from its position as an unbiased authority, at least in those respects where it is most interesting to physicians.

The chemical portion has been under the charge of Prof. Sadler, while Prof. Remington has given his attention more especially to the strictly pharmaceutical aspects of the revision.

The publishers have done their part with a great deal of judgment, and the volume, though bulky, is not inordinately so, and is well bound and neatly printed.

The Medical and Surgical History of the War of the Rebellion, Part III., Vol. II. Surgical History. Washington, 1883.

This magnificent volume is a worthy continuation of its predecessors. At no time previously has such a monument to the devotion of the surgical staff of an army been consecrated by the country which was aided by their endeavors. The text is 986 large quarto pages, the woodcuts are 510 in number, and there are 44 full-page, most admirably executed, chromo-lithographic plates.

This volume closes the surgical series of the Medical and Surgical History of the War of the Rebellion. It embraces wounds and injuries of the lower extremity, miscellaneous injuries, the complications of wounds (hemorrhages, tetanus, erysipelas, pyæmia, etc.), anæsthetics, *materia chirurgica*, and the transportation of the wounded. Full indices close the volume.

It is a subject of national congratulation that the Government authorities have been willing to put forth these volumes. They will prove to the historian of the future one of the main landmarks in the development of military surgery; and the practical benefit of the extensive induction from carefully recorded facts they will confer, will long remain as a testimony to one of the collateral advantages which even war brings with it.

The Pathology and Treatment of Diseases of the Ovaries. By Lawson Tait, M. R. C. S., etc. Fourth Edition. New York: Wm. Wood & Co., 1883. Clo., 8vo., pp. 357.

Diagnosis of Ovarian Cysts by means of the Examination of their Contents. By Henry J. Garrigues, A. M., M. D., etc. New York: Wm. Wood & Co., 1882. Clo., 8vo., pp. 112.

Mr. Tait's book has grown in the ten years since its first appearance, from the size of a prize essay, as it then was, into a treatise of considerable bulk. This growth has been a normal one. The author's constantly enlarging experience, the remarkable improvements which have taken place in abdominal surgery of recent years, and the much closer means of diagnosis which a decade brings with it, all demanded a material enlargement of his earlier editions. He has accomplished this faithfully and successfully, so that really there is no point in the study of ovarian disease that is not discussed with fulness in this volume. It is no doubt the best monograph on the subject in our language.

Dr. Garrigues confines his attention to the elucidation of one single disputed question in ovarian surgery; that is, whether the fluid of an ovarian cyst offers a reliable means of diagnosing the character of that cyst. How much need there was and is for this discussion is evident from the opinions entertained by the two writers before us. Mr. Tait writes (p. 146): "Professor John Hughes Bennet, Dr. Drysdale, Mr. Thornton, and several others, have all fallen into the error of believing that any one form of cell can be made diagnostic of these growths." Dr. Garrigues draws the conclusion (p. 103) that "by studying the physical, chemical, and microscopic characters of the fluid, it is almost always possible to diagnosticate ovarian cysts, even without knowing anything about the patient." Dr. Garrigues, however, also rejects Drysdale's "granular ovarian cell," which, indeed, he says is not a cell at all, but a degenerated nucleus.

Both these books should be in the library of every working gynecologist.

April 14, 1883.]

Editorial.

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THE
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D. G. BRINTON, M. D., }
JOSEPH F. EDWARDS, M. D., } EDITORS.

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THE TREATMENT OF ACUTE RHEUMATISM.

While the chemical theory which refers the joint troubles and the cardiac complications to an acid circulating in the blood, (says Dr. Robert Bartholow, *Medical Record*, January 6, 1883,) receives support from clinical facts and from the results of experience, yet there is an influence behind those chemical processes, which is concerned in the secondary assimilation, to produce an excess of acid, and which, we have many reasons for believing, proceeds from the nervous system. It may be affirmed that joint affections closely related to rheumatism are caused by certain spinal and nerve lesions, and hence we may regard it as probable, if not proved, that in the treatment of acute rheumatism we have to deal with a neurotic affection. In spare persons of considerable bodily vigor, good muscular development, and having a distinct family history of neurotic or rheumatical disorders, who are prone to indulge in a rich diet of animal food, sauces and wines, and to pursue sedentary occupations, salicylic acid or salicylate of soda renders incontestable service, no doubt due to its power to diminish the irritation of the trophic nervous system. They should be given in full doses and continued after the subsidence of the acute symptoms, and the cessation of the fever and pain, for the same number of days as the acute attack lasted. Thus, if the decline of fever and pain occurred on the fourth day, the remedy should be continued as many days thereafter, or for four days subsequent to the apparent cessation of the acute symptoms.

The second class of rheumatic subjects contains the obese or those of full habit, the rotund addicted to malt liquors and to good living, all of whom are apt to suffer from a form of acid indigestion. The cases of rheumatism occurring in such subjects are, as a rule, much benefited by the alkaline treatment.

"By the 'alkaline treatment,'" says Dr. Fuller, "I mean a plan of treatment in which alkalies play an important part, but which consists not only in the administration of alkalies, but in the careful regulation of the secretions, the strictest attention to diet, and the administration of

tonics, such as quinine and bark, as soon as the patient can bear them. * * * My practice is to give not less than an ounce and a half of the alkaline carbonates, either alone or in combination with a vegetable acid, during the first twenty-four hours of treatment. * * * More commonly two drachms are ordered to be taken in effervescence every three or four hours in combination with an ounce of lemon-juice, or with half a drachm of citric acid dissolved in four ounces of water. At the same time, if the bowels are torpid, ten grains of colocynth and calomel pill (British Pharm.) are prescribed at bed-time. As soon as the urine, when freshly voided, ceases to show an acid reaction—which is usually the case after twenty-four hours—the quantity of the alkali is diminished by one-half, six drachms only being administered during the succeeding twenty-four hours. At the expiration of that time, if the urine remains alkaline, three drachms only are given in the next twenty-four hours; and on the fourth day, if the urine still shows an alkaline reaction, the form of the medicine is altogether changed. The treatment ceases to be essentially alkaline; either a cinchona draught is ordered to be taken three times a day, containing a scruple or a half drachm of bicarbonate of potash—a little more or a little less, according to the condition of the urine, which should be kept nearly neutral—or three grains of quinine dissolved in lemon-juice is given three times a day in effervescence, with half a drachm of bicarbonate of potash or soda. * * * The diet is restricted to beef-tea or broth, with soda-water and milk, and barley-water as a drink, as the smallest quantity of solid food, given a day before the tongue has thoroughly cleaned, is apt to induce a recrudescence of the disease. Wine and spirits are strictly forbidden, though experience has convinced me that wine and spirits prove less hurtful than the smallest quantity of solid food.

"In my experience, the special peculiarity of acute rheumatism in these obese subjects is the tendency to assume a sub-acute character, and to be delayed in the progress toward recovery. They are also more liable to heart complications."

The alkaline treatment, carried out as above described, gives better results in respect to relief to suffering, to duration of the disease, and freedom from complications.

The third type of rheumatic cases and numerically the most important—probably, also, pathologically, the most serious—is the feeble and anaemic subject. A rheumatic of this kind is pale, rather thin, the muscles weak and wanting in firmness, the chest narrow and somewhat flat, the joints prominent and lax. In such persons an extension of the rheumatic inflammation from joint to joint, until almost all the joints of the body are involved, is to be feared, as it is of frequent occurrence. Cardiac complications are relatively frequent. It need hardly be observed that in such subjects the depressing effects of salicylic acid and the alkalies are to be dreaded. Here clinical experience is in entire accord with theory. We owe to Dr. Russell Reynolds, of London, the introduction of a remedy for acute rheumatism, which is especially suited to this group of cases. I refer to the *tincture of the chloride of iron*. To be effective, it must be given in full doses—from 3 ss. 3 j. in sufficient water, every four to eight hours. It lessens the swelling and pain of the joints, lowers the fever, diminishes the tendency to heart complication, and, above all, sustains the vital powers in their struggle against the encroachments of the rheumatic disease.

A combination of the blister treatment with salicylic acid, with alkalies, or with the tincture of iron, may often be made with signal advantage.

It will sometimes produce strangury. Milk and animal broths should constitute the exclusive diet until the cessation of all joint troubles; and atropine (if efficient) is preferable to morphia as an anodyne.

PROTECTION FROM YELLOW FEVER.

It does seem difficult to impress upon our people the importance of sanitary precautions; but when once taught their significance by great calamities, there are many among us wise enough not to forget or neglect their dearly-bought experience.

There is still lingering in the minds of the majority a distrust of the results of investigation and of the preventive and protective power of hygiene; they preferring rather to give adherence to the barbarous, superstitious, and exploded view of the inevitability of disease and its visitation upon man as a punishment for wrong-doing.

That it is not inevitable, we, who read hygiene, full well know; that it is a divine visitation as a punishment, we also know; for could a people more thoroughly merit punishment than when they wilfully and deliberately neglect the warnings, the writings, and the words of those earnest philanthropists who study that they may learn how to prevent and control disease, and write, that they may impart this almost divine knowledge to their fellow-men?

We would ask whether, in the light of accepted sanitary dogmas, the city of Philadelphia does not eminently deserve the most serious punishment that the most severe epidemic could inflict upon her, when her people put into control men who outrage all sanitary laws, and who permit our streets, for months at a time, to remain in a condition in comparison with which the foulest pig-pen would be a model of cleanliness? When the rains of spring are succeeded by the heat of summer, who can foretell how terrible may be the ravages of epidemic diseases in our midst?

Poor fever-stricken Memphis has learnt its lesson, and we all remember at what a terrible price.

We learn that the authorities there, owing to the unsatisfactory condition of the laws governing quarantine at the mouth of the Mississippi, have decided on self-protection. The Legislature has been petitioned for an appropriation to defray the expenses of local quarantine in case of necessity. A thorough house-to-house inspection is being made, and every building, front and back yards, outhouses, stables, etc., will be thoroughly examined, with a view to having them put in the most complete sanitary condition.

The President of the Council backs up the proclamation with the warning that the owners of unsanitary premises will be punished to the full-

est extent of the law for violations of the sanitary ordinance. This system of inspection will be continued throughout the summer, and until all possibility of danger is passed. The first intimation of yellow fever or other contagious diseases, at New Orleans or other points on the lower Mississippi, will be the signal for the establishment of a rigid quarantine against the places. The troubles of 1878 and 1879 have not been forgotten, and the authorities are determined that they shall not be repeated, if it is in the power of man to prevent them.

NOTES AND COMMENTS.

Interstitial Tubo-Gestation.

In the *British Medical Journal*, Dr. Henry Habgood describes the case of a married woman, aged 35, who died with all the symptoms of internal haemorrhage, in the eleventh week of pregnancy.

"At the necropsy, there were about five pints of clotted blood in the pelvic and abdominal cavities. On turning this out, the source of the haemorrhage proved to be a sac, formed by the uterine portion of the left Fallopian tube and the wall of the uterus, which had grown outwardly to about the size of a walnut, and then ruptured anteriorly. Chorion villi were distinctly visible in the sac. The opening of the tube into the sac had become obliterated. There was evidence of a previous partial rupture, in the shape of a small haematocele, on the posterior aspect of the sac. The fetus had escaped into the abdominal cavity, and was unfortunately lost. The left ovary was closely attached to the left side of the uterus by old bands of lymph, and contained several cysts. The right ovary was normal, and contained a corpus luteum. The uterus was enlarged, and its lining membrane was red and thickened, forming a distinct decidua, that could be easily detached. The bladder was healthy, but contained no urine. The abdominal organs were healthy, but very anemic.

"With regard to the cause of the arrest of the ovum in that particular spot, I may remark that nothing existed in the Fallopian tube or uterus, in the shape of polypus or fibroid, to cause obstruction, but that there were plenty of adhesions on the left side, matting the uterus, Fallopian tube and ovary together, altering their relative positions, and, possibly, causing obstruction. Yet the presence of a corpus luteum in the right ovary,

coupled with the cystic condition of the left, would point to the theory of transmigration of the ovum as being the most probable explanation of the phenomenon."

The Electrical Treatment of Enlarged Glands.

In the *Med. Press and Cir.*, January 17, 1883, Dr. Hercules H. MacDonnell recommends the following modification of Mr. Golding Bird's procedure:

Having selected the gland or mass of glands you purpose treating, have the surface well cleaned and wiped over with a solution of salt. Apply the negative pole of a Leclanché battery, having two cells connected, over the most prominent part, and the positive about three inches apart; keep moving the positive reophore in a circle round the negative quite slowly, till the electrical stimulus has been sufficiently applied. Usually, five to six minutes is long enough. On the first occasion two cells are enough, as it accustoms the tissues to the action. On the succeeding applications, the effect of additional cells may be tried; but should there be the slightest appearance of inflammatory action, as evidenced by a bluish-white tint under the negative reophore, a couple of cells must be at once disconnected, or the application discontinued on that occasion. I have never used more than eighteen cells continued for three minutes, and have found that from eight to twelve cells give the most satisfactory and rapid results. The length of each application varies for different individuals. In some patients three or four minutes twice daily seemed to suffice; in others a longer application only once answered better. Even different glands or masses of glands in the same individual, progressed more rapidly under varying conditions of length, strength, and frequency of application.

Fair-skinned patients bear a more heroic line of treatment better than dark ones, and react more quickly to the electrical stimulus.

Naphthol in Itch.

The *Med. Times and Gaz.*, February 3, 1883, says:

Introduced by Prof. Kaposi, of Vienna, naphthol has been substituted by him for tar in some affections of the skin, as eczema, psoriasis, prurigo, and especially itch. It has scarcely any odor, and even after long exposure to air only becomes of a pinkish color, which does not permanently stain the linen. Prof. Hardy, it is stated in a *thèse* by Dr. Guérin, has substituted a very simple formula for the complicated one of Kaposi,

consisting in vaseline 100 parts to 10 parts of naphthol. The pulverized naphthol is dissolved in half its weight of ether, and is then mixed with a portion of the vaseline, and heated to 30° to 40° Cent., until the ether is entirely evaporated. The rest of the vaseline is then added, and the mass carefully triturated. The homogeneous pomade which is produced is kept secluded from the air. It may be applied at all periods of itch, whether complicated or not; and it is applicable also to the eruptions which supervene in the course of itch, and for which sulphur ointment is unsuited. The furrows are by this ointment rapidly freed of their inhabitants, and other eruptions disappear. The treatment lasts from ten to fifteen days, which is very much longer than Prof. Hardy's rapid treatment by sulphur; but when we consider how long the itching persists often after the cure by sulphur—sometimes obstinately continuing for months—the treatment by naphthol is practically the shorter of the two. M. Guérin has never observed any ill-effects upon the kidneys result from naphthol.

Hysterectomy.

This being still a comparatively rare operation, the following case is worthy of record (*New York Medical Journal*, January 27, 1883): The patient first came to the Woman's Hospital five years ago, suffering from procidentia of the uterus, which was partially relieved by certain plastic operations on the vagina. Last spring Dr. Emmet performed Le Fort's operation, which proved successful; but some months afterward the patient gave way to a fit of anger, and the uterus, which contained a large fibroid tumor, was again crowded down toward the vulva. The patient was suffering greatly from pain, and desired to have the tumor removed. Dr. Emmet performed the operation, removing the body of the uterus with a portion of the cervix, the ovaries, and the tubes. The mass was composed of eight fibroids, mostly intra-mural. In order to avoid haemorrhage, Dr. Emmet made use of a plan first introduced, he believed, by Olshausen, but since constantly practiced in England, viz., that of encircling the whole mass at its base by a long piece of Esmarch's tubing prior to its amputation. This tubing, being put about the tumor at full tension, was grasped at the point of crossing of the two extremities by a strong forceps, and this was firmly held by an assistant. Prior to the removal of this constrictor, he secured the stump in the Kréberlé serréœud, having previously transfix it with two needles. The abdominal wound was then

closed, and the pedicle was thoroughly smeared with Monsel's salt. At the present time, the beginning of the fifth day, the patient was doing well.

A New Treatment of Dysentery.

Dr. F. Rawle recommends the following treatment in the *Brit. Med. Jour.*, January 27, 1883:

First, having placed the patient between warm blankets, I proceed to inject a pint and a half of warm water, at a temperature of 90° Fahr. This is seldom retained longer than a few minutes, but is pronounced very grateful to the patient. When the water has soothed the mucous membrane of the colon and rectum, and brought away any *effete* matter, I then proceed to administer a small injection of two ounces, by measure, with a gum-elastic bottle. The form I administer is the following:

R. Quiniaz disulphat.,	gr. x.
Tinct. camphoræ comp.,	3 iv.
Decoctum amyli ad	3 ij.
M., and when about milk-warm, inject.	

It is generally retained, but if ejected, it may be repeated after an hour or two. This I have found of great service, and very grateful to the patient. I do not stop to inquire how it acts, but the effect is like magic. If griping pains be felt over the region of the epigastrium, I administer half-drachm doses of chlorodyne, in some aromatic water; mint, caraway, or aniseed. The diet, of course, should be of the most soothing kind: jellies, isinglass, linseed, toast and barley water, *ad libitum*. Ipecacuanha I have found of little service, and have discarded it from my treatment. If any of my medical brethren will try these measures, he will not often be disappointed. I have used with advantage warm turpentine stupes on warm flannels, over the hypogastrium.

Esophagotomy.

On September 4, 1882 (*Med. Times and Gaz.*, January 13th, 1883), external esophagotomy was performed in the Kommune hospital at Copenhagen by Dr. Holmer. The patient, a man aged thirty, was a lunatic who had swallowed a stone with suicidal intention two days before. The foreign body became impacted in the gullet a little below the larynx, and could not be dislodged either upwards or downwards. The accident was further complicated by the "cradle" of Gräfe's coin-catcher having become detached during the attempts to extract the stone, and remaining in the gullet. Dr. Holmer then made an incision along the anterior border of the sterno-mastoid muscle,

and opened the oesophagus over the site of the impacted substances. The little "cradle" was first removed, and, after a good deal of trouble, the stone was seized with a pair of forceps such as are used for lithotomy in children, and extracted. The stone was found to be five centimetres long, by five centimetres wide at its broadest part. The wound was dressed with iodoform, and the patient made a rapid recovery. His voice, however, remained hoarse, owing to paralysis of the left vocal cord. This was possibly due to injury of the left recurrent nerve during the operation, but Dr. Holmer thinks it more probable that it was caused by the pressure of the stone, as the patient's voice was husky when he first came under observation.

Iodoform in Puerperal Fever.

The *Am. Jour. of Obstetrics*, February, 1883, says that Maggioli of Rome, in the *Gaz. Med. di Roma*, viii. 1, agrees with Spiegelberg in the necessity of applying antisepctic principles to the treatment of puerperal cases, but not entirely in what Spiegelberg calls secondary antiseptics. Iodoform internally is useful in puerperal cases for many reasons: it is readily absorbed and readily tolerated by the mucous membrane of the stomach and intestines: it is readily diffused, and the iodine is found (after the administration of iodoform) in the urine, saliva, tears, sweat, milk, nasal mucus, menstrual blood, and in the air expired from the lungs. The iodine reaction may be obtained from the urine as late as four days after the administration of the last dose. From two to three grammes may be given daily without harm. Nine-tenths of the weight of a given quantity of iodoform consist of iodine. The generally accepted beneficence of this substance as a topical application suggests its utility as a means of internal medication. The author's experience is limited to four cases of puerperal fever, in which the results were very favorable. Two additional cases were treated by Moleschott, the substance being used in the form of an unguent and rubbed into the skin.

A New Operation for Spina Bifida.

From the *Brit. Medical Jour.*, December 30, 1882, we note that Mr. Robson recently performed a new operation for spina bifida on a child six days old. After the redundant parts were removed, and after stitching up the arachnoid over the spinal canal, periosteum from a rabbit was inserted between the meninges and the skin, so as to cover the gap in the bones. The wound had perfectly healed; the skin over the lumbar region

was quite level; there seemed to be no tenderness on pressure; the child looked strong and healthy. The sac was found to be of the size and shape of half a swan's egg; the wall consisting of true skin and subcutaneous tissue lined by serous membrane. Mr. Robson drew attention to the following points:

1. The operation was performed with full anti-septic precautions, eucalyptus air being used instead of carbolic spray.

2. The meninges were closed by uniting the serous surfaces, as in peritoneal surgery.

3. The transplantation of living periosteum and its continued vitality; it had not yet, however, formed new bone, but already the covering of the canal had a greater than mere skin-firmness.

4. The entire absence of bad symptoms in the child, operated upon at so early an age, was noticed.

Results of Excision of the Pylorus.

The *Med. Times and Gaz.*, January 27th, 1883, says that Dr. Rydygier, in a recent number of *Volkmann's Sammlung*, thus sums up the results of the operations hitherto performed. Sixteen surgeons have operated upon twenty-three cases, all but two of which have been examples of cancer. Of these last two operations one was performed by Rydygier in a case of stenosis caused by round ulcer, which terminated successfully; and the other by Lauenstein in a case of supposed cancerous tumour, which at the autopsy proved to be one of gangrene of the transverse colon. Of the twenty-three cases, nineteen proved fatal, viz., fifteen some hours after the operation, three on the seventh or eighth day, and one (Billroth's) four months after, from relapse. Of the four recoveries, one belongs to Billroth (no relapse having occurred in six months), one to Wölfler (the patient seeming well at the end of a year), one to Czerny (seven months without a relapse), and one to Rydygier.

Dr. Cattaneo's Treatment of Hydrocele.

From the *Jour. de Med. de Paris* we note the following treatment recommended by Dr. C.:

1. Puncture of the hydrocele with a capillary trocar of an aspirator, and evacuation of the fluid.

2. Injection of a solution of hydrate of chloral in quantity proportionate to the volume of the hydrocele and age of the patient: one to two grams of chloral for children, four grams for adults, and occasionally more in old men. The solution is made by dissolving equal parts of chloral in cold distilled water.

3. Cold applications, to overcome the pain produced by the injection.

4. The injection is repeated if the absorption occurs too slowly.

The patients are kept in bed, and wear a suspensory bandage for some time after the termination of treatment. Dr. Lampagnani says that the effusion has not returned in any one of the seventeen cases operated upon by this method.

Labor Complicated by Lipoma of Labium Majus.

In the *Centralbl. für Gyn.*, Bruntzel records the case of a primipara in which a tumor, the size of a hen's egg, had existed for four years, which had never given any trouble, save an occasional prolapso after severe efforts. After she had been in labor twenty-four hours, the tumor was drawn out and held to one side by means of a towel, and the child was delivered with the forceps without rupturing either the perineum or the tumor. The latter had seemed to develop on account of the pressure which had been brought to bear upon it during the labor, and afterward seemed harder and less movable. The latter facts caused a change in the diagnosis, which had originally been that of hernia labialis. Three months later the tumor was removed, as it had become a source of great annoyance to the patient.

Uraemic Seizures.

The *London Med. Record*, Feb. 15, 1883, says:

Dr. Rühle (*Trans. of German Med. Congress*, 1882,) states that in every case of death from uræmic convulsions, oedema of the brain is found to exist. But simple oedema of the brain does not cause convulsions, and some toxic agent must be added to the serous exudation to produce this condition. That chemical changes accompany the uræmic attacks, is shown by the fact that the gastric secretions become alkaline, and that the breath turns litmus-paper blue. So soon, therefore, as oedema of the brain comes on in the course of these, as yet, undefined blood-changes, it acts as a poison and gives rise to convulsions.

Nervous Cough.

Before a recent meeting of the Boston Society for Medical Improvement (*Boston M. and S. Jour.*, March 29, 1883), Dr. Bowditch reported a case of cough lasting sixteen months, apparently, except for the duration and violence, a case of typical whooping-cough. Laryngoscopic examination showed nothing. At the lowest part of the chest, outside the heart, was crepitus for a space of

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one or two inches, but no dullness. He supposed the cough to be nervous.

Dr. Knight said that he had seen many cases of what he thought nervous cough, and which were usually benefited by nerve sedatives. One case had yielded to enormous doses of quinine, beginning with two grains, and gradually reaching fifteen or twenty at a dose.

Surgical Treatment of Intestinal Obstruction.

In acute intestinal obstruction that will not yield to massage, cathartics, and enemata, Dr. Krönlein (*Correspondenzblatt für Schweizer Ärzte*, Nos. 15 and 16, 1882), recommends laparo-enterotomy. An incision is made in the right iliac region, and the portion of the gut which presents at the opening is seized and stitched to the abdominal wall. If the intestinal canal become permeable again, the artificial anus may be closed; but, in any event, he does not consider that life with an artificial anus is so unendurable as many are accustomed to suppose.

Electrical Treatment of Epigastric Pains in Hysteria.

The *Chicago Med. Jour.*, Feb., 1883, says: These pains, which are mostly accompanied by severe vomiting, have been successfully treated with the galvanic current by Dr. Apostoli. The positive pole is applied in the subclavicular region, and the negative pole over the seat of the pain. It is continued for 5 to 15 minutes, and it is said to have stopped the vomiting entirely. The gastralgia and epigastric pains have been stopped after ten to fifteen applications.

The Frequency of and Danger from Narrow Pelvis.

The *Medical Record*, January 6, 1883, says that Dr. W. Fishel read a paper before the German Medical Society of Prague, in which he stated that the usual estimates of the frequency of narrow pelvis in Germany were too high. These estimates made the proportion vary between 14 and 20 per cent. Hecker, of Munich, found the per cent. to be only 1.5; Müller, in Berne, 16; Goerner, in Basel, 7; Winckel, in Dresden, 3; Fishel, in Prague, 15.6. In Breisky's clinic, at Prague, the mortality in these cases was only 1.5 per cent.

Spontaneous Separation of the Funis.

Dr. Burge reported the following case to the Rhode Island Medical Society (*Boston M. and S. Jour.*, March 29, 1883):

While the mother was attempting to rise from the bed, the child was born, and dropped to the

floor, breaking the funis about five inches from the umbilicus. Dr. Burge arrived soon afterwards, and found the child alive and crying vigorously. He ligated the cord as a matter of routine, though there had been no hemorrhage.

Rupture of the Pulmonary Artery.

A man, apparently in perfect health, was suddenly attacked with severe pains in the chest and extreme anxiety and difficulty of respiration, which, after thirty hours, terminated in death. Dr. Arro, who reports the case in the *Rivista de Ciencias Med.*, December 10th, 1882, found at the autopsy a rent in the pulmonary artery, from which a large amount of blood had escaped into the chest.

A New Protective.

Dr. Malinin (*Mediz. Oboz.*) recommends mixing, collodium 1b j, castor oil 3j, almond oil 3ss, and carbolized oil 3 iij-3 iv, and spreading it over a glass plate smeared with glycerine. The fluid rapidly dries, forming a transparent, thin, soft, and light sheet, which, when used, suffers no alterations from the contact with wound-discharges, and may be employed repeatedly (of course, each time after its washing in a carbolic solution).

CORRESPONDENCE.

Consulting Clairvoyants.

EDS. MED. AND SURG. REPORTER:

Your reply to "Dr. T. W. E., of Ohio," relative to the absurdity of consulting clairvoyants by sending a lock of hair, reminds me of an incident occurring in my own practice several years since, that is too good to be lost. I had a patient with mitral regurgitation, and some of the officious old women who thought I might be mistaken in my diagnosis, advised the wife of my patient to send a lock of his hair without his knowledge to a notorious clairvoyant, which she did, but without stating the sex of the patient. In due course of time a reply came back from the clairvoyant, that after "going through the patient's system" she found the trouble to be *ulceration of the womb*, and that if the patient was placed under her special care, she would readily cure, etc. It is needless to state that she failed to convince Mrs. — that her husband had any such physiological appendage, with its attendant diseases.

Stonington, Conn. GEO. W. STANTON, M. D.

Prof. Smith's Frequent Repetition.

EDS. MED. AND SURG. REPORTER:

You quote from the *N. Y. Med. Jour.*, an article by Dr. A. A. Smith, Professor of Materia Medica in Bellevue, which you call "valuable," and which, if true, is not only valuable but a trifle startling.

Here we find it gravely stated that half a drop of Fowler's solution will cure the vomiting after a debauch.

That in *pseudo croup* a single teaspoonful at a dose of a solution of one one-hundredth of a grain of *atropine* in a glass of water will give prompt relief.

That drop doses of *chamomile* will quickly relieve many complaints of nervous babies.

That a single drop of wine of *ippecac* will often produce the most marked relief both from vomiting and diarrhoea.

That teaspoonful doses of a solution of *corrosive sublimate*, one grain to a quart of water, is curative in mucous passages from enteritis.

That another extraordinary statement, which at first seemed to me to be "fabulous," is, "put a grain of *tartar emetic* into one quart of water: teaspoonful doses every half-hour will relieve the wheezing and cough accompanying a slight bronchitis in children."

Further on: *cantharides* in insignificant doses is recommended in vesical catarrh; single drop doses of *digitalis* in heart affections; *castor oil* in diarrhoea; *pulsatilla* in orchitis and dysmenorrhoea; *ergot* in amenorrhoea; *aconite* in fever, with bounding pulse and hot, dry skin; and more of the same sort.

Now I confess I was set back by an article in your journal some five years ago, by Charles H. Hall, M. D., upon *corrosive sublimate* in dysentery, in which he claimed remarkable success with "small and frequently-repeated doses," frankly admitting that the principle and practice was homeopathic, and boldly charging Ringer, who recommends it, with plagiarism. Hall says, "Any one who is curious on the subject of his small doses, not only in this disease, but in almost every other one of his recommendations, has only to refer to homeopathic works, and find that he has plagiarized."*

But here is more of the same kind, and by a Professor of *Materia Medica*. Does it not strike you, Messrs. Editors, that Prof. Smith's recital of therapeutic wonders is overwhelmingly open to the same criticism? Upon what principle does he studiously ignore the source of his practice? It would certainly redound to the credit of the profession if a more frank and manly stand were taken in just such matters.

Pittsburgh, Pa. J. H. McCLELLAND, M. D.

(Prof. Smith is a distinguished gentleman, and the journal from which we noted his remarks is reputable. If he derives his practice from the source our correspondent assumes, he is perfectly right, and Prof. Smith should openly state that such is the case—EDS. REPORTER.)

NEWS AND MISCELLANY.

Medico-Chirurgical College.

The commencement exercises of the Medico-Chirurgical College took place in Association Hall on the evening of March 29.

After prayer by Rev. John B. Dales, the address to the graduates was delivered by the Dean of the Faculty, Prof. William S. Stewart, who concluded

by conferring the degrees. The prizes were awarded as follows:

Faculty prize of a gold medal for the best thesis and examination, to Henry Fisher, with honorable mention of Frederick Loos, Jr.

Especial honorable mention of the thesis of Richard Vallancey Danne, for its elaborate character and unusual excellence.

Especial honorable mention of the examination of Mr. Frederick Loos, Jr., he having passed the best examination before the adjunct faculty.

Mitchell Chemistry prize of a Beck's Histological and Dissecting Microscope, awarded by the Professor of Chemistry for the best thesis upon a subject in medical chemistry showing original research, to Frederick Loos, Jr., with honorable mention of the theses of Henry Fisher and Emil M. Herwig.

Surgical prize of a gold medal, awarded by the Professor of Surgery for the best thesis and final examination upon surgery, to Bernard Marquis Goldberg, M. D., with honorable mention of the examination of Julian Frank Meade.

Prizes by the Adjunct Faculty.—A prize of a laryngoscope, awarded by the Professor of Diseases of the Throat and Upper Air Passages for the best examination in his branch, to Frederick Loos, Jr.

Christine prize to John S. Stewart.

Rev. Dr. Richard Vallancey Danne, of Melbourne, Australia, delivered the valedictory.

The Charges against Drs. Beates and McDowell Withdrawn.

The charges of conspiracy preferred against these gentlemen have been withdrawn, as testified by the following letter:

DEAR SIR: I am satisfied upon reflection that I was wholly mistaken in believing that any conspiracy had taken place between you and Dr. McDowell to obtain any part of the property of Catherine Potts, now deceased, or for any other purpose; no such conspiracy, or any conspiracy, I am now satisfied, ever existed on the part of either of you. I admit that anything that I may have testified in the above suit before Magistrate Robert R. Smith to that effect was incorrect, and that I was mistaken therein, and that I desire to withdraw all charges to that effect against either of you which I have made, as I am now satisfied of my error, and desire to make every reparation in my power to both of you. I regret extremely the publicity given to the matter, and authorize you to make any use of this letter you wish. For these reasons, and with the approval of both my counsel, I have requested that a *nolle pros.* may be entered in the above suit, and I learn that the same has been done with the approval of Magistrate Smith, of the District Attorney, and of Judge Yerkes. Hoping this may in some degree excuse what I formerly did, I remain yours respectfully,

JOSEPH B. NAULTY.

To Henry Beates, Jr., M. D.

Right-Handedness.

From the *Bost. Med. and Surg. Jour.*, March 29th, 1883, we learn that Dr. Goëtan Delaunay has communicated an interesting paper to the French Anthropological Society, in which he seeks to establish that right-handedness is not an acquired

habit, but is a natural attribute characteristic of the superior races. Savage tribes, he states, and communities in an inferior state of civilization, show a much larger proportion of left-handedness than highly civilized peoples do. Idiots and epileptics offer a very large percentage of left-handed individuals, and there are more left-handed women than men. His general conclusion is that in the evolution of the species there has been a steady tendency to the development of the right side of the body at the expense of the other, and that the examples of left-handedness still to be met with in the superior races are mere "survivals."

Therapeutic Improvements.

American Lint.

Among recent surgical improvements should be named in the first line a form of lint brought forward by Messrs. Seabury & Johnson. They produce it directly from the best quality of cotton, and from a careful examination which we have recently made of it, we place it as easily equal to the first-class products of foreign makers.

Jensen's Beef Peptones.

These excellent preparations deserve the attentive consideration of the physician. They find their place in the nutrition of infants, convalescents, dyspeptics, the aged, and those of impaired assimilation generally. Dr. Jensen has studied most thoroughly the methods of obtaining these organic products in a pure and palatable form; and from some personal experience and observation with them, we can say that he has reached a most successful result.

Mortality Rates.

In some of the principal cities of the world the rates of mortality per 1,000 of the various populations were, according to the latest official returns, as follows: Calcutta, 34; Bombay, 25; Madras, 33; Paris, 26; Geneva, 18; Brussels, 23; Amsterdam, 26; Rotterdam, 29; the Hague, 26; Copenhagen, 21; Stockholm, 22; Christiana, 21; St. Petersburg, 45; Berlin, 22; Hamburg, 23; Dresden, 23; Breslau, 26; Munich, 28; Vienna, 24; Prague, 25; Buda-Pesth, 26; Trieste, 31; Rome, 23; Turin, 20; Venice, 26; New York, 21; Brooklyn, 21; Philadelphia, 19; and Baltimore, 27.

An Ingenious Device for Supporting a Hospital.

Mr. Arthur Keugh, of London, has hit upon an ingenious plan for getting funds for the Dental Hospital. He has started a "cigar thrift fund." He places boxes in cigar shops, clubs, smoking-rooms, etc., in which the ends of cigars can be placed. They are valuable enough, if the system is sufficiently widespread, to bring in a considerable sum of money annually. There is also a small cigar-cutter for the waistcoat pocket which preserves the tips, and these gentlemen themselves can save and forward.

Rhode Island Delegates to Am. Med. Association.

The following gentlemen have been elected delegates from the Rhode Island Medical Society to the American Medical Association: W. E. Anthony, D. H. Batchelder, W. S. Bowen, W. J. Burge, S.

B. Church, S. W. Francis, G. D. Hersey, S. Hunt, J. Kenyon, G. H. Kenyon, C. B. Mathewson, H. G. Miller, C. W. Parsons, H. J. Pomroy, F. H. Rankin, A. A. Saunders, G. W. Stanley, O. C. Wiggin.

Pensions.

The Pension Bill was passed by Congress January 13th. The following are some of the items: For army pensions, \$80,000,000; for navy pensions, \$1,000,000. Fees and expenses for examining surgeons, \$275,000. The allowance of from \$12 to \$35 per month is made for the loss of an eye, and \$50 per month for both eyes, while the loss of hearing is estimated at \$25 per month.

Items.

An ophthalmic and aural book club has been started in this city, Dr. L. Webster Fox, secretary.

A six-year-old's idea of the umbilicus. While studying his anatomy during the administration of a bath, this hopeful (son of a physician) remarked: "Mamma, I think the navel must be where I was finished off!"

Spirit of turpentine is now made from sawdust and refuse of the saw-mill. It is extracted by a sweating process, and yields 14 gallons of spirit, 3 to 4 gallons of resin, and a quantity of tar, per cord. The spirit produced has a different odor from that produced by distillation.

A dealer in boots and shoes, to make his sign striking, had lettered upon it, "mens conscientia recti." A rival in the vicinity, wishing to outdo his competitor, had his sign emblazoned with "mens and womens conscientia recti." The latter was not in good Latin, but it drew the most customers.

It is a Hebrew proverb, "When the sun rises the disease will abate." It originated from a tradition that Abraham wore a precious stone round his neck, which preserved him from disease, and which cured sickness when looked upon. When Abraham died, God placed this stone in the sun.

A medical student at Bowdoin College once asked the late Prof. Parker Cleaveland if there were not some more recent works on anatomy than those in the college library. "Young man," said the professor, "there have been very few new bones added to the human body during the last ten years."

It is stated that an employer of young men in Manchester, England, has decided that he would not allow salaries to any of his clerks who were injured in foot-ball matches, "as the game was too dangerous to be played with safety, and he did not feel it right that he should pay for absences caused in this manner."

James T. Fields used to tell this story of Dr. Channing: "The reverend doctor and the medical doctor were both at a party in Boston one evening, and, some one being taken ill, the man of medicines, Dr. Walter Channing, was summoned. The servant entered the room where the brothers were seated, and said, 'Dr. Channing is wanted.' 'Which Dr. Channing?' said Walter the physician; 'the one who preaches, or the one who practices?'"

Notice the Wrappers!

As we now print the address of subscribers on the wrappers of the *REPORTER*, and add to it the date to which they have paid their subscriptions, we beg all readers to notice the date, and remit if they are in arrears. If this is promptly attended to, it will save the business management of the journal the annoying necessity of sending bills or "duns," which are always unpleasant to receive and to present.

OBITUARY NOTICES.**GENERAL JOSEPH K. BARNES.**

General Joseph K. Barnes, ex-Surgeon-General U. S. Army, died of Bright's disease on the morning of April 5th.

He was born in Philadelphia, July 21st, 1817. Graduating from the University of Pennsylvania in 1838, he served a term in Blockley Hospital, was district physician for a while, and finally was appointed Assistant Surgeon in the army, June 15th, 1840.

In November of the same year he was sent to Florida, where he saw his first field service in Gen. Harney's famous expedition to the Everglades, in the war against the Seminole Indians. He remained with Gen. Harney's command in Florida two years, and in 1842 was transferred to Fort Jessup, an old-time military station in Louisiana, where he served until its abandonment, four years later. At the breaking out of the Mexican war in 1846, the young surgeon, then only twenty-nine years of age, was appointed chief medical officer of the cavalry brigade, and in that capacity he participated in every action of the war in either Gen. Taylor's or Gen. Scott's lines, excepting that at Buena Vista, and at the close of the hostilities was placed in charge of the general army hospital at Baton Rouge, La. For the next few years he rendered valuable service to the Government in organizing medical posts at various stations in Texas and throughout the West, acting for a short period as Medical Director of the Department of Oregon. He was assigned to duty at West Point again in 1854, and served there several years. In 1856 he received his commission as a Surgeon.

At the outbreak of the war of the Rebellion, Surgeon Barnes was stationed in Oregon, and was among the first officers to be called to Washington. In 1861 he was assigned to special duty in the office of the Surgeon-General at Washington, where his experience in field and hospital service was of great value to the Government. Two years later he was promoted to be a Medical Inspector, with the rank of Lieutenant-Colonel, and a few months afterwards he was appointed Medical Inspector-General, with the rank of Colonel. In September, 1863, he was made Acting Surgeon-General, and one year later, on the dismissal of Surgeon-General Hammond, was promoted to fill the vacancy, with the rank of Brigadier-General. He served during the war with great honor, and in 1865 received the brevet rank of Major-General. He was the first physician called to the bedside of President Lincoln when he was assassinated, April 15, 1865, and had charge of the case until its fatal termination. On July 2, 1881, when the late President Garfield was shot, he was among

the first physicians to be summoned to the White House, and served on the consulting board of physicians until the death of the President, giving the case his closest attention. He was placed on the retired list last year by the operation of the compulsory retirement law, and has since then been living quietly at his residence in Washington.

The General had a fine, erect, military bearing. His complexion was rich and ruddy, and his hair iron gray. He was agreeable in his manners, and socially was a wonderfully entertaining conversationalist. In his profession he stood deservedly high, and was universally respected by all who knew him.

He was buried in Oak Hill Cemetery on Saturday, April 6, the following gentlemen acting as pall-bearers: Gens. W. T. Sherman, Edmund Schriver, D. H. Rucker, W. H. Emory, A. Baird, M. C. Meigs, R. C. Drum, R. MacFeely, N. W. Brown, C. H. Crane, C. M. Wilcox, and Joseph E. Johnstone.

M. P. BARKER, M. D.

Dr. M. P. Barker, of Newcastle, Pa., author of a series of articles on "Medical Missions in Heathen Lands," which recently appeared in the *REPORTER*, died March 31, 1883. He was born in Sandy Lake, Mercer county, March 27, 1829. Was a graduate of Cleveland Medical College, and of the University of Pennsylvania. He located in Newcastle in 1861, and soon built up a large and lucrative practice. He was a thoroughly conscientious and skillful physician, and his life record was written in deeds. He was thrown from his horse about three years ago and received injuries of a serious character, which finally culminated in his demise. He was a member of the Presbyterian Church, holding the office of elder since 1865. Three daughters (his wife having died a few years ago) are left to mourn the loss of an affectionate father, and the community in which he lived will feel the loss of a talented and kind-hearted citizen.

S. S., M. D.

MARRIAGES.

COLE-SMITH.—At Pelleville, N. J., Wednesday, April 4, by the Rev. William M. Sandford, Theodore Cole, M. D., of this city, and Miss May Smith, of Hatfield, Mass.

DEATHS.

BAILEY.—At Bailey Homestead, Kent Cliff, Putnam county, N. Y., Dr. Joseph H. Bailey, U. S. Army (retired), in his 80th year.

HEADLEY.—In New York, Saturday, March 31, at his late residence, William S. Headley, M. D.

SHACKELTON.—On Sunday, April 1, at his late residence, Mattawan, N. J., Judson G. Shackelton, M. D., in the 47th year of his age.

TUNSTALL.—On April 1, 1883, at his residence, Norfolk, Va., Dr. Robert B. Tunstall, in the 65th year of his age.

VAN BUREN.—In New York city, March 25, No. 1 Park Avenue, Dr. William H. Van Buren, in the 64th year of his age.

SUNDBERG.—On March 19, 1883, Cynthia, wife of Dr. John C. Sundberg, of Seattle, W. T.

Dr. John W. Ferguson, lately from Charleston, was found dead just beyond the city limits on April 1. He is supposed to have committed suicide by poison.

Dr. Nathaniel Low died at Dover, N. H., April 2, aged 90 years. He was graduated at Dartmouth in 1809, and held numerous offices of trust in New Hampshire and Maine.